

1 IN THE CIRCUIT COURT OF THE
2 11th JUDICIAL CIRCUIT, IN AND
3 FOR DADE COUNTY, FLORIDA
4 CASE NO. 94-08273 CA (20)
5
6 HOWARD A. ENGLE, M.D., etc., et al.,
7 Plaintiffs.
8 v.
9 RJ REYNOLDS TOBACCO COMPANY, etc., et al.,
10 Defendants.
11
12 599 Lexington Avenue
13 New York, New York
14 April 14, 1997
15 Monday, 9:40 A.M.
16
17 DEPOSITION OF ANDREW SCHINDLER
18
19 Taken before Richard O. Applebaum,
20 Shorthand Reporter, Notary Public for the State of
21 Florida at Large, pursuant to Notice of Taking
22 Deposition filed in the above cause.
23
24 KLEIN, BURY & ASSOCIATES, INC.
25

1 APPEARANCES:
2
3 STANLEY ROSENBLATT, P.A.
4 By: STANLEY ROSENBLATT, ESQUIRE
5 AND SUSAN ROSENBLATT, ESQUIRE
6 on behalf of the Plaintiff.
7
8 JONES, DAY, REAVIS & POGUE
9 By: ROBERT WEBER, ESQUIRE
10 AND HUGH WHITING, ESQUIRE
11 on behalf of the Defendant/RJ Reynolds.
12 KING & SPALDING
13 By: MICHAEL RUSS, ESQUIRE
14 on behalf of the Defendant/B & W.
15 KASOWITZ, BENSON, TORRES & FRIEDMAN
16 By: MARIE SANTACROCE, ESQUIRE
17 on behalf of the Defendant/Liggett.
18 SHOOK, HARDY & BACON
19 By: DAVID HARDY, ESQUIRE
20 on behalf of the Defendant/Lorillard.
21 GREENBERG, TRAUERIG, HOFFMAN, LIPOFF, ROSEN &
22 QUENTEL, P.A.
23 By: DAVID ROSS, ESQUIRE
24 on behalf of the Defendant/Lorillard.
25
26 ANDERSON, MOSS, SHEROUSE & PETROS
27 By: EDWARD MOSS, ESQUIRE
28 on behalf of the Defendant/B & W.
29
30 ALSO PRESENT: CHARLES BLIXT, ESQUIRE
31
32 KLEIN, BURY & ASSOCIATES, INC.

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30 KLEIN, BURY & ASSOCIATES, INC.

1 Thereupon:
2 ANDREW SCHINDLER
3 was called as a witness on behalf of the Plaintiff and,
4 having been first duly sworn, was examined and
5 testified as follows:
6 MR. WEBER: Stanley, before we get
7 started, I just want to confirm for the record
8 that the camera will be - remain focused on the
9 witness, without any zooming in or out, it will
10 just remain stationary; is that correct?
11 THE VIDEOGRAPHER: Yes.
12 MR. ROSENBLATT: Yes. That was my
13 understanding.
14 DIRECT EXAMINATION
15 Q. (By Mr. Rosenblatt) Please tell us your
16 name and your business address.
17 A. Andrew J. Schindler. Business address is
18 Fourth and Main Street, Winston-Salem, North Carolina.
19 Q. What is your present position with R.J.
20 Reynolds?
21 A. I'm president and CEO of R.J. Reynolds
22 Tobacco.
23 Q. And how long have you occupied those
24 joint positions?
25 A. Since July of 1995.
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1 Q. What was your position immediately before
2 assuming those two jobs?
3 A. I was president and chief operating
4 officer of R.J. Reynolds Tobacco Company.
5 Q. When did you begin with R.J. Reynolds?
6 A. I began - I joined the company in May of
7 1974.
8 Q. And it's been continuous employment,
9 you've never left for a period of time and been
10 employed by someone else?
11 A. It's been continuous employment with the
12 RJR family of companies, yes.
13 Q. What are R.J. Reynolds Tobacco Company
14 leading brands today?
15 A. Leading brands are Doral, which is our
16 actually today number one brand, Winston, Salem and
17 Camel.
18 Q. What percentage of the market does Doral
19 have, the total tobacco market?
20 A. Doral has about five and a half share
21 points or so.
22 Q. Compared to Marlboro, for example, which,
23 as I understand it, is the leading brand; correct?
24 A. Yes, Marlboro is the leading brand. It's
25 at 31, 32 share points of the market.
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1 on the market because of various types of discounting
2 that go on in the market. So it would be somewhere on
3 average about a dollar or a 1.80 a pack, 1-78, 1.90.
4 Depends on what market you're in and what type of
5 discounting activity goes on.

6 Q. Okay. And how about the Doral discount
7 brand, what does that sell for?

8 A. That will be again depending on what goes
9 on in the marketplace, somewhere around 1.40, 1.45,
10 1.35, 1.39, it varies.

11 Q. Do you have a background in marketing?

12 A. I'm - if you'd explain the meaning in
13 terms of my career, in terms of being - prior to
14 getting into this job, being in the marketing --

15 Q. No. In terms either of this job with
16 Reynolds or any previous job have you --

17 A. Well, I was in the sales organization in
18 the mid-70s.

19 Q. Of Reynolds?

20 A. Of Reynolds.

21 And then my direct marketing line
22 accountability is what I have done since I've been in
23 this job as president.

24 Q. How would you define marketing?

25 A. Marketing is the organization within the
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1 company who's accountable for understanding consumer
2 needs and is responsible for, you know, the
3 advertising, promotion of the brands to our smokers
4 and trying to convince competitive smokers to smoke
5 our products. They're accountable for the
6 advertising, the positioning of the brand, its image,
7 product difference, communicating that to smokers, and
8 to advertising through promotion, discounting, pricing
9 and so forth.

10 Q. In terms of the way the concept of
11 marketing is usually used, if, for example, if Winston
12 or Doral were to overtake Marlboro, that would be a
13 marketing triumph for R J. Reynolds, wouldn't it?

14 MR. WEBER: Let me object to the form.

15 Q. That means you can answer.

16 MR. WEBER: You can go ahead. I'm
17 objecting to the way the question was framed
18 with the introduction to it.

19 A. Could you repeat the question?

20 Q. Yes.

21 I'm saying if one of your brands Winston
22 or Doral, which is obviously today very far behind
23 Marlboro, if one of those brands were to overtake
24 Marlboro in terms of the industry and in terms of the
25 way it would be perceived, that would be a tremendous
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9

1 marketing triumph, wouldn't it?

2 MR. WEBER: Same objection.

3 Go ahead.

4 A. If one of those brands happened somewhere
5 to get a higher share of market than Marlboro, it
6 would be certainly a success for that brand, which
7 everyone did that.

8 Q. No.

9 Would it be a marketing success?

10 A. It would be a business success and to
11 what degree it would be a marketing success I would
12 assume that would have something to do with it, but it
13 would be a success to gain market share and to somehow
14 surpass Marlboro, which I think is a highly
15 theoretical sort of achievement or opportunity.

16 Q. How long has Marlboro been number one?

17 A. As near as I can remember, I believe that
18 Marlboro became the number one brand in the late '70s,
19 somewhere in the 1978 or 1979.

20 Q. In terms of the history of the tobacco
21 industry, is it fair to say it's very unusual for one
22 brand to be the leader for that long?

23 I mean, in Marlboro's case we're talking
24 what, 27, 28 years?

25 MR. WEBER: Object to form.

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10

1 Go ahead.

2 A. Well, Marlboro's been the industry leader
3 for about 18 years or so.

4 You know, historically I don't know the
5 time frames, but there have been various brands
6 historically in the industry, Lucky Strike was the
7 number one brand for some period of time and I don't
8 remember the exact number of years, Camel was the
9 leading brand for awhile.

10 Q. But isn't it your understanding --

11 MR. WEBER: Were you done?

12 Q. Yes.

13 Were you done?

14 A. Yes.

15 Q. Okay. Isn't it your understanding,
16 though, that Camel or Lucky Strike while they were
17 number one for a period of time was a lot less than
18 18 years?

19 A. I really don't know the time frame.

20 Q. Okay. What do you attribute the success
21 of Marlboro to for these past 18 years, their
22 marketing, their advertising or what?

23 A. I would attribute it to two things. I
24 think they had a good marketing campaign with Marlboro
25 Country and I think they had an excellent product.
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11

1 Q. That's what I was getting at.

2 Now, you referred to Marlboro Country,
3 which we - I certainly assume you're referring to the
4 cowboy motif?

5 A. Yes. The whole western.

6 Q. Right.

7 The advertising that one sees on
8 billboards with horses and cowboys and nature and that
9 kind of thing, and that's - that would come under the
10 heading of marketing?

11 MR. WEBER: Let me object.

12 Q. Is that correct?

13 MR. WEBER: Let me object to the form.
14 Go ahead.

15 A. Well, to me the comprehensive sense of
16 marketing I think it's whatever your advertising is as
17 well as your product itself. So I would attribute any
18 brand's success to both of those components.

19 Q. Well, I mean, if we were to forget
20 totally - put aside totally the advertising, the
21 marketing, media, and we just took a Winston and a
22 Marlboro, are you satisfied the Marlboro tobacco is
23 somehow inherently better than Winston or Doral?

24 A. I believe over the years that Marlboro
25 has a product that has tasted different than Winston
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12

1 and it is obviously by its share of market preferred
2 by the majority - you know, a large majority or a lot
3 of the people in the marketplace.

4 So it's hard for me to separate those two
5 things, because I believe that it's both - that the
6 marketing of a product has to do with the product
7 itself as well as, you know, whatever the advertising
8 is with it. So I think they're both part of whatever
9 makes a brand successful.

10 Q. Since you've been with Reynolds have you
11 ever conducted blindfold tests?

12 You know what I mean by that?

13 A. On what?

14 Q. Okay. Where you would test whether or
15 not smokers blindfolded, without seeing the package,
16 could distinguish, okay, now I'm smoking a Winston, 20
17 minutes later I'm smoking a Marlboro, are you familiar
18 with that kind of test?

19 A. You're talking about blind product
20 testing?

21 Q. Exactly.

22 A. Where they don't know what the brand is,
23 there's no brand identifier, they're just smoking
24 cigarettes and you're asking for their opinion?

25 Q. Exactly.

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13

1 A. Yes, we have done blind product testing.
2 Q. And what have you found in that kind of
3 testing?

4 A. What we have found in blind product
5 testing, that if you take Winston, for example, that
6 typically Marlboro, say like Marlboro Lights, for
7 example, would be preferred over Winston Lights by the
8 smokers that you've on a blind basis test against.

9 Q. Okay. What I'm trying to understand is,
10 does the average smoker know blindfolded that he's now
11 smoking a Marlboro as opposed to a Winston?

12 Do you have research on that?
13 A. The research that we do doesn't ask - on
14 a blind basis you're not asking somebody if they can
15 identify is this a Marlboro or is this a Winston.

16 You're asking them to evaluate which of
17 these cigarettes they prefer or how - well, actually,
18 most of the time it's one group will get Marlboros,
19 another group will get, let's say, Winston, and then
20 they'll be some attributes that they rate it against
21 in terms of smoothness and harshness and things of
22 that nature and overall preference.

23 You're not asking them can you identify
24 the brand, you're asking them to make a judgment about
25 how they view the taste of that product and then how
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14

1 the other smokers view the taste of Winstons and that
2 gives you a sense on a blind basis of just the taste
3 of the product.

4 And out of that process you get numbers,
5 you get quantitative scores on those judgments.

6 And typically our experience has been
7 that Marlboro will be preferred as a product, it will
8 get higher scores in that kind of testing than will
9 Winston.

10 Q. All right. Are you aware of any research
11 either conducted by Reynolds or any other tobacco
12 company which pinpoints whether a smoker can identify
13 the difference between cigarettes blindfolded, not
14 which he prefers, but simply knowing blindfolded, hey,
15 now I'm smoking a Marlboro, now I'm smoking a Camel?

16 MR. WEBER: Object to the form.
17 Go ahead.

18 A. I don't know of any research that we have
19 ever done on a blind basis you're asking somebody --

20 Q. What kind of cigarette he's smoking?

21 A. -- is this a Marlboro? Is this a
22 Winston?

23 I don't know of any research like that.

24 Q. Okay. Are you a smoker?

25 A. Yes, I am.

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1 Q. And how old were you when you started
2 smoking?

3 A. I think I was probably about 18 or so.
4 It was somewhere - I got out of high school in 1962.
5 It was somewhere after I got out of high school.

6 Q. Do you remember the circumstances what
7 attracted you, what started you smoking?

8 A. No. I mean the - the specifics, no. I
9 just know that I was smoking. Friends smoked, my
10 father smoked. It was, you know, friends and
11 relatives. I just became a smoker.

12 Q. Okay. Have you smoked continuously from
13 the time you're 18 up until today or was there ever a
14 period of time where you decided to quit and did quit?

15 A. I quit - the first time I quit smoking
16 was in - when I was in Viet Nam in 1969. I quit
17 smoking at that point.

18 Q. I would have thought that's when a lot of
19 people started smoking when they were in Viet Nam.

20 A. Well, it was certainly a stressful
21 environment. I was an infantry officer, actually up
22 with the First Air Cavalry Division up along the
23 Cambodian border. I had a staff job at that point, a
24 fire base.

25 And I don't know, as I recall, I had a
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1 real bad cold that went on for a period of time and I
2 just stopped smoking because of the irritation and
3 that sort of thing with the cold. I didn't smoke --
4 after that. I still had, as I recall, another six
5 months in Viet Nam at that point.

6 Q. So for how long a period of time did you
7 stop smoking?

8 A. As near as I can remember, I believe the
9 next time I started smoking - I think it was about
10 seven years. It was somewhere after I joined the
11 company. I joined the company in '74 and I believe I
12 started smoking again somewhere in '76 or something
13 like that, as near - as best as I can remember.

14 Q. So you --

15 A. So that was seven years.

16 Q. So you smoked from age 18 until what age?

17 A. '69 is 25.

18 Q. Okay. And at --

19 A. Twenty-four, 25.

20 Q. Okay. Give or take.

21 And at that point in time you stopped
22 smoking for seven years?

23 A. Yes, as near as I remember.

24 Q. Okay. During the period of time you
25 smoked from 18 to 25, give or take, how heavy a smoker
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17

1 were you?

2 A. I was probably a pack or pack and a half
3 a day, except when I was in Viet Nam. I was smoking
4 more when I was in Viet Nam.

5 Q. Well, as you look back, was it
6 essentially the cold that you could not get rid of
7 that caused you to stop smoking?

8 A. No.

9 Look, we're back almost 30 years. I
10 remember that I had a cold and it was irritating so I
11 didn't smoke while I had that cold. And after the
12 cold went away, I just didn't smoke again.

13 Q. Okay. Do you remember the circumstances
14 of --

15 Now you go seven years you're a nonsmoker
16 and then one day you start smoking again.

17 Was there a social circumstance or
18 another kind of circumstance where one day after seven
19 years you said to yourself well, I'm going to start
20 smoking again?

21 A. As I recall, at that time I was working -
22 I was working in the sales organization at Reynolds
23 and somewhere in the process I, you know, started
24 smoking again.

25 Q. From that time until today have you been
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1 a constant smoker or has there been another segment of
2 time where you stopped?

3 A. There was one other time that I stopped
4 smoking, and I was a plant manager for the company in
5 - and I started that job in October of '81, and I
6 stopped smoking as a plant manager, and I think it was
7 somewhere in 1985 or so, as I recall.

8 Q. It was sometime in '85 when you stopped
9 smoking?

10 A. Yes.

11 Q. Okay. And did you have another cold or
12 what caused you to stop smoking in '85?

13 A. No. I just decided I didn't want to
14 smoke and I just stopped smoking.

15 Q. And how long did you stop smoking?

16 Because you're telling me now you're a
17 smoker.

18 A. Yes.

19 Q. Okay. So in '85 you stopped smoking for
20 how long?

21 A. It was three or four years, as I recall,
22 as best as I can remember that.

23 Q. Do you remember if there was any pressure
24 from family, wife, kids, who wanted you to stop
25 smoking in '85, or was it totally unrelated?

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1 A. No. It was unrelated. I don't recall
2 any pressure from family whatsoever.
3 Q. -Do you remember the circumstances in 1988
4 or 1989 when you would have started smoking again, or
5 was it just you just picked up a cigarette?
6 A. Well, I just started smoking again.
7 Q. And nothing stands out in your mind as to
8 the circumstance, as to why you started smoking again?
9 A. No, nothing in particular.
10 Q. Okay. And once you started smoking again
11 in the late '80s, have you been a continuous smoker
12 from then until today?
13 A. Yes.
14 Q. Okay. How heavy a smoker are you today?
15 A. Pack, pack and a half a day.
16 Q. What brand?
17 A. Well --
18 Q. Not Marlboro?
19 A. No, I don't smoke Marlboros.
20 It's - I'll smoke all of the Reynolds
21 products at some point or another. Smoke a cigar once
22 in a while.
23 And as a regular brand, I smoke Eclipse,
24 I mean is the most normal - constant brand in that.
25 Basically, I'll smoke Camels, I'll smoke Winstons,
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1 Salems, a variety of our products, but no competitive
2 products.
3 Q. From approximately age 18 to about age 25
4 what brand did you smoke?
5 A. I smoked Winstons and I smoked - I
6 remember smoking Larks for awhile. Those are the only
7 two that I can remember.
8 Q. So basically in your career as a smoker
9 there have been basically two stretches where you've
10 stopped smoking completely, one for approximately
11 seven years and one for approximately three or four
12 years?
13 A. Yes.
14 Q. When you stopped smoking on those
15 occasions, did you - were you able to stop smoking
16 without any difficulty?
17 A. Yes.
18 I describe dthe situation in Viet Nam
19 when I stopped smoking. I just stopped.
20 Q. And never started again until seven years
21 later?
22 A. Yes.
23 Q. And you had know problems? You didn't
24 miss the cigarettes?
25 A. Well, I think - well, I don't - it's hard
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21

1 to remember the '69 thing in detail. All I remember
2 is that I stopped smoking and didn't start again,
3 didn't become a smoker again for seven years.
4 Q. Okay. And I'm certainly not asking you
5 for detail, but as you remember the experience of
6 stopping smoking when you were about 25 years of age,
7 you were able to quit smoking without any difficulty?
8 A. Yes.
9 Q. And that was also your experience in the
10 late '80s when you stopped smoking for three or four
11 years, you were able to do so without any difficulty?
12 A. Yes.
13 Q. Are the warning labels on your cigarettes
14 that you sell to the American public, are they true?
15 A. I'm - what do you mean are they true?
16 Q. Are they true?
17 One of the warnings on packages of
18 cigarettes which you sell in the billions to the
19 American public says smoking causes lung cancer, heart
20 disease, emphysema and may complicate pregnancy.
21 All I'm simply asking you, is that true?
22 MR. WEBER: Let me object to that for
23 misstating what the warning says.
24 Q. (By Mr. Rosenblatt) Well, it says -
25 before that it says we always have someone technical,
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1 Surgeon General's warning, smoking causes lung cancer,
2 heart disease, emphysema and may complicate pregnancy.
3 And my question to you is, is that true?
4 A. I think it's true that the Surgeon
5 General says, who I believe created the warning label
6 that we, you know, put on our packs, the Surgeon
7 General says that cigarettes cause those diseases.
8 Q. Isn't it Congress who did that?
9 A. Well, Congress working I guess through
10 the Surgeon General, public health people and Congress
11 said this is the law, this is the warning label to go
12 on the packs, which says that the Surgeon General says
13 that cigarettes cause these diseases.
14 Q. Mr. Schindler, obviously I'm not asking
15 you is it true if the Surgeon General says that and
16 I'm not asking you is it true that that warning
17 appears on your cigarettes.
18 I'm asking you whether the statement is
19 true?
20 A. My --
21 MR. WEBER: Wait. Wait. Let me object
22 to that for the whole introduction, Stanley,
23 because it wasn't obvious to me --
24 If that's your new question, go ahead.
25 A. My view is that cigarettes are a risk
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23

1 factor for those diseases, that they may cause those
2 diseases. I do not know if they do cause those
3 diseases.
4 The warning label that was given to the
5 industry by Congress and the Surgeon General says that
6 the Surgeon General says that it causes those
7 diseases.
8 My view is, that cigarette smoking is a
9 risk factor for those diseases and it may cause those
10 diseases. I do not know if it does or doesn't in that
11 sense. I believe that maybe it's a risk factor.
12 So in that context, I don't know if that
13 statement of it causes is true or not.
14 It's what people believe that provided
15 the label to us or the warning label.
16 Q. Now, as I've heard your answer, and have
17 understood your answer, it is your view that the
18 statement that smoking causes lung cancer, heart
19 disease, emphysema, is inaccurate, because you believe
20 that the accurate statement should say that smoking is
21 a risk factor for those diseases as opposed to saying
22 it causes those diseases?
23 MR. WEBER: Let me object for
24 mischaracterizing what he just said.
25 You can answer.
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24

1 A. I believe that cigarette smoking is a
2 risk factor for those those diseases, which to me
3 means that it may cause those diseases. That's my
4 point of view.
5 Q. I understand that.
6 But therefore, having said that,
7 obviously then from your point of view a statement
8 which says cigarette smoking causes lung cancer is not
9 accurate; correct?
10 A. Well, like I said, Mr. Rosenblatt, I
11 believe that cigarettes are a risk factor for these
12 diseases and I believe that therefore that means to me
13 that they may cause those diseases. That's, you know
14 that's my point of view.
15 Q. What is another risk factor for lung
16 cancer?
17 Smoking is one of them, according to you.
18 What's another one?
19 A. Well, I would think that there are things
20 related to genetics, perhaps the diet, exercise or
21 look thereof, and a variety of things that may also be
22 risk factors related to smoking. Family history, I
23 guess, which relates to genetics, and a number of
24 things, environmental factors, where you live and so
25 forth.
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25

Q. Tell me how you think exercise or the look thereof is related to lung cancer?

You mean if someone jogs a lot they may get lung cancer?

A. It is my understanding of - that - I'm not a scientist, obviously, but it's my understanding of epidemiology that cigarette smoking is identified as a risk factor and that there may be in things I have heard or read over time that there are other factors that may relate to - as risk factors for certain diseases, talking about lung cancer here, which could involve genetic makeup, could involve environmental, where you live, perhaps diet, perhaps not having enough exercise in combination in some factor are the risk factors related to these certain diseases.

Q. So on the issue of causation, your view is maybe smoking causes lung cancer and maybe it doesn't?

A. It is my view that cigarette smoking has been shown through all of the epidemiology research and studies over the years that it is a risk factor for lung cancer and other diseases and therefore may be a cause of those diseases, but that from the standpoint of scientific proof in terms of mechanism
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and exactly how it might be the cause, that has not been formally determined in the scientific process.

So I view cigarette smoking as a risk factor that may cause these diseases and that, you know, that's my view.

Q. This is your personal view or is this the company's view?

A. Well, it's my view, it's the view of scientists that I've talked to with the company that have studied this issue, that are up on the research and literature, and people I've talked to over time about the whole issue of smoking and health.

Q. Mr. Schindler, would you agree or not agree that there is a worldwide consensus in the medical community and in the scientific community that cigarette smoking causes lung cancer or do you think there is a controversy within the medical community and scientific community on that subject?

A. I would agree that the majority - clearly the majority of people in the public health field have stated that cigarettes cause these diseases.

It is my view that it is a risk factor for those diseases and may cause the diseases that we're talking about.

Q. Have you ever read an article in the New
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England Journal of Medicine or any prestigious peer reviewed medical journal in this country where a physician, an M.D., unconnected to the tobacco industry has taken the position that smoking is merely a risk factor for lung disease and there's no scientific evidence that it causes lung cancer?

MR. WEBER: Let me object.

If you're trying to state what he said, you mischaracterized it with that material that you said in the end.

If it's entirely different question, then I'll just object to the form.

Go ahead.

A. Could you ask the question again, please?

(Thereupon, the requested portion of the record was read back as above recorded.)

A. I have never read an article that you've described like this. I have never read an article in the New England Journal of Medicine like you've described.

I believe that cigarettes are a risk factor and that - I believe that very strongly.

And as a company we have acted upon that belief by trying to improve products and as an industry over a 30, 40 year period, with the lowering
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of tar in cigarettes, with work we've done in recent years on products like Eclipse.

That the fact that I believe that it may -- cause these diseases, to me what is relevant is what does the company and the industry - what has it done relative to acting upon the fact that it is a risk factor. And I believe that we have done a lot over the years to address these issues with lowering of tar and that - trying to create products that address the risk related to smoking.

Q. (By Mr. Rosenblatt) How many billions of cigarettes does R.J. Reynolds Tobacco Company sell in a year?

A. About 120 billion is our volume.

Q. 120 billion with a B, with a B?

A. It's 120 billion cigarettes a year.

Q. Okay. I just wanted to make sure people are not confusing that with million.

A. No.

Q. Okay. Now, don't you think as the president and CEO of a company that sells that many billions of cigarettes to the American consumer, and you admit that it may cause lung cancer and heart disease, that you have a responsibility to read some of the independent literature so that you would know
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what the scientists and the medical doctors are saying?

A. Well, I am aware of what medical science and the doctors are saying. I spent time with our own people in the organization that I manage discussing these issues and I - they are competent, ethical people. We've spent a fair amount of time discussing the whole smoking and health issues.

And I am very comfortable with my own personal belief that cigarettes are a risk factor for these diseases and am comfortable with what we have done as a company to address the risks that are associated with smoking, in terms of trying to improve the product over time, with the lowering of tar and other work that we have done over the years.

Q. So the lowering of tar makes cigarette smoking less of a risk factor?

A. I don't know if it makes it less of a risk factor, but for a number of years up until as near as I understand this until the late '70s there was a sort of cooperative effort between the public health community and the industry to address tar as an issue with regard to potential of risk in cigarettes and a very concerted effort over a 20 or so year period to systematically work to deliver or design and
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manufacture cigarettes that have substantial reduction in tar, which is the history of the industry and working with public health people up until I understand around the late '70s.

So there has been an effort over the years to reduce tar in cigarettes as the area that tended to be a consensus of where the risk may lie with regard to cigarettes.

Q. Which of the Reynolds products has the highest degree of tar?

A. I believe the highest tar would be More 120s, it's a 120 millimeter small circumference cigarette.

Q. Do you know the percentage of tar expressed in milligrams?

A. I believe it would be around 21 or so milligrams of tar.

MR. WEBER: Just for the record, I think you misstated. It's not a percentage of tar, I think you --

A. It's actual 21 milligrams.

Q. Okay. 21 milligrams?

A. (Witness nods).

Q. What is the lowest Reynolds product in terms of tar?

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1 A. It would be a Now product, which would be
2 about one milligram of tar.
3 Q. - Well, are you telling us that Now in your
4 judgment is much less of a risk factor than More?
5 A. No, I'm not saying that.
6 I'm saying it has substantially less tar.
7 I'm saying that over the years the
8 industry working for a good period of time with public
9 health people said that reduction in tar was the right
10 thing to do with the design of cigarettes, that we as
11 an industry and we as a company worked hard on
12 providing products that reduce tar so that all
13 cigarettes today are substantially less tar today than
14 they were 30 or 40 years ago.
15 As to whether or not that product is less
16 risky than a higher tar product, I don't know. I know
17 that it has less tar, which is an area of focus that
18 the public health people have had for years.
19 Q. But so what?
20 In other words, if less tar is not safer
21 than more tar, than for me as a consumer, so what?
22 More has 21 milligrams, Now has one
23 milligram. Okay. One has 20 more milligrams than the
24 other, but so what?
25 Why should that be significant to me as a
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1 consumer?
2 A. I'm not sure I understand your question.
3 Q. You're telling me it doesn't have any
4 health consequences.
5 So I'm saying to you, other than saying
6 More has 21 and Now has one, I'm asking you as a
7 consumer well, so what?
8 What's the significance of that 20
9 difference?
10 MR. WEBER: Let me object to the form of
11 that. I'm not even sure what the question is
12 myself.
13 Go ahead and answer.
14 A. I'm not sure I understand the question.
15 I'm not trying to be obstinate here. I'm just not
16 sure --
17 Could you repeat it?
18 Q. I'll ask it a different way.
19 Aren't you suggesting in your
20 advertisements of less tar that less tar is less of a
21 health risk to smokers?
22 A. I don't believe we're suggesting that in
23 the advertising.
24 I think what we're saying in ads, which
25 is a regulation that we operate under, that if we run
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1 an advertisement or a piece of point of sale, that
2 we're required to indicate what the tar and nicotine
3 is by the FTC, that we're reporting what it is for
4 that particular product that the ad is running for.
5 So I - I don't believe there's any
6 suggestion in the advertising that it is, I believe as
7 you said, a less risky product. It just - it has
8 let's tar.
9 Q. Which signifies what?
10 A. That there's less tar in the product.
11 There's no - there's nothing about us
12 following the government regulation to indicate what
13 the tar and nicotine levels are in a product. It's
14 saying that we're suggesting or saying it's less tar.
15 There's been or had been over the years a
16 joint effort between public health people and the
17 companies to create products that have less tar
18 because the consensus was that whatever the risk is in
19 cigarettes, that a general reduction in tar would be
20 the right thing to do. So the industry working in the
21 earlier days in a collaborative mode with public
22 health people reduced the tar.
23 Whether or not those products have less
24 risk in them is something that would have to be
25 determined over a long period of time. Maybe they do,
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1 maybe they don't, but the consensus was from the
2 public health people that the right thing to do was to
3 reduce the tar levels.
4 Q. Follow this hypothetical question. A
5 friend of yours says to you as follows, I'm a smoker
6 and I'm - you know, I'm getting a little worried by
7 virtue of the Surgeon General's warning and I've done
8 some reading and I'm really worried about whether
9 smoking is gonna give me lung cancer or any other
10 disease, but I really - you know, I really enjoy
11 smoking. I don't really care what brand I smoke, all
12 I really need is that jolt of nicotine. I'm happy
13 with any brand. Now, I noticed that your product Now
14 has one milligram of tar and I've been smoking More
15 with 21 milligrams of tar. Don't you recommend that I
16 smoke Now?
17 MR. WEBER: Let me object to the form of
18 the question.
19 Q. What would your answer be?
20 MR. WEBER: Same objection.
21 Q. What would your answer be to that
22 question?
23 You're the president of R.J. Reynolds. I
24 can smoke More or I can Now, and I'm asking you for
25 your recommendation since Now contains one milligram
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1 of tars, I'm smoking More with 21 milligrams of tar
2 and I ask you, Mr. Schindler, aren't I better off
3 smoking Now. What's your answer?
4 MR. WEBER: Same objection.
5 A. Well, in in hypothetical question you've
6 put on the table I would tell my friend the same thing
7 I told you, what I know about the whole issue related
8 to tar levels, that public health people felt years
9 ago that it was - it was the right thing to do for
10 these products to be designed in such a way that the
11 tar level would be brought down.
12 If that person said to me do you think
13 this product is safer, which I think is what you're
14 implying in your hypothetical question, I'd tell them
15 I have no idea.
16 I'd just tell you what I know that public
17 health people have said and you make up your own
18 choice.
19 I don't really know if it reduces risk or
20 if you're implying safer in this question, which I
21 sense you are, I would tell them essentially the same
22 thing I've told you and they would be free to make up
23 their mind.
24 Q. In this hypothetical the friend - he's a
25 friend of yours, is simply saying, you know, Andy, I'm
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1 not interested in the history, I'm simply asking you,
2 I want a direct answer Now or More, I want your
3 recommendation, should I smoke Now or More, don't give
4 me history. I just want a one word answer Now or
5 More.
6 Are you able to give me a one word
7 answer?
8 MR. WEBER: Objection on form and asked
9 and answered. He just answered that question.
10 A. Well, I would answer the question the way
11 I just answered it to you.
12 Q. Okay.
13 A. That's what I would tell my friend.
14 I'm not in control of my friend's
15 decision-making process. They're asking me for
16 information and I would provide them what I know and
17 they would make their decision.
18 Q. In my hypothetical your friend is not
19 asking you for information and he's not asking you for
20 a discourse, he's asking you should I smoke More or
21 Now in your opinion? I may not follow your advice.
22 I'm simply asking you do you recommend that I smoke
23 Now because it has less milligrams of tar or you're
24 not giving me an answer?
25 MR. WEBER: Same objection.
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1 I'm not even sure that was a question at
2 the end, Stanley.
3 Q. Question mark.
4 MR. WEBER: Can you read that back for me
5 please?
6 (Thereupon, the requested portion of the
7 record was read back as above recorded.)
8 Q. The question is, do you tell your friend
9 obviously you're going to do what you want but I
10 recommend that you smoke Now or do you not answer the
11 question directly?
12 MR. WEBER: Let me object both on form
13 and asked and answered. But go ahead.
14 A. I think I've already answered this --
15 Q. Okay.
16 A. -- to you.
17 I would share my information with them,
18 what I understand about tar levels.
19 If my friend asked me do you believe that
20 a cigarette with less tar is less risky, I'd say I
21 don't know. It may be, it may not be.
22 I would only - I would share with them
23 what I understand. I wouldn't want to mislead a
24 friend.
25 And the guidance from public health
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1 people over the years had been to reduce tar levels, I
2 believe on the theory that that would be a better
3 product, so we have worked as an industry to do that.
4 This hypothetical question as to whether
5 or not it is or isn't safer, I don't know.
6 But I would share with them what I
7 understand and that it may be, but it may not be. And
8 it would - I just don't have the data to make that
9 kind of definitive answer to someone.
10 Q. You wouldn't want to mislead a friend.
11 But aren't you in fact misleading the
12 American public when you state under oath in 1997 that
13 it is your view that the Surgeon General's warning on
14 your packs of cigarettes which say smoking causes lung
15 cancer, you're saying that's not accurate, it's only a
16 risk factor.
17 Isn't that misleading the American
18 public?
19 MR. WEBER: Let me object to the form and
20 also object to asked and answered. We went
21 through his position on the Surgeon General
22 warnings a half hour ago.
23 A. I don't --
24 MR. ROSENBLATT: Now in Florida we don't
25 have speaking objections, you know, because it
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1 disrupts the train of thought. It interrupts
2 the dialog. There's no necessity for that.
3 Now obviously he's forgot the question.
4 Q. (By Mr. Rosenblatt) Or, do you have it
5 in mind?
6 A. I'd prefer that you repeat it after this
7 back and forth.
8 (Thereupon, the requested portion of the
9 record was read back as above recorded.)
10 A. I don't believe I'm misleading the
11 American public. I'm not sitting here in that
12 context. You're asking me my point of view.
13 And my point of view is that cigarette
14 smoking is risk factor for these diseases, which to me
15 means that it may cause these diseases.
16 And I recognize that that point of view
17 is different than what is - the Surgeon General has on
18 the warning label.
19 But to me the issue is, if I believe that
20 cigarettes may cause these diseases, to me the real
21 question is what have we done as company to respond to
22 that? Do we ignore it or do we work to address how to
23 improve products over time?
24 We've done through this earlier in this
25 deposition that we have worked to address those issues
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1 that the public health community believes that may
2 relate to the risks associated with smoking. That's
3 what we have done.
4 Q. I am not asking you for your point of
5 view.
6 I am asking you as the president and CEO
7 of a company that sells billions of cigarettes to the
8 American consumer what evidence you have to say that
9 smoking doesn't cause disease but it's merely a risk
10 factor?
11 And you're telling me, as I've understood
12 it, that you're telling us this and it's your point of
13 view based on discussions with technical people you've
14 had at Reynolds; is that essentially correct?
15 MR. WEBER: Let me object to the form.
16 A. Well, I --
17 Q. He said yes.
18 A. I'm assuming you asked me a question.
19 Q. Yes.
20 A. I didn't say that cigarette smoking
21 doesn't cause diseases, which I believe is the way you
22 characterized it.
23 I said that it may, that it's a risk
24 factor, that it may cause, but that science in the
25 sense of laboratory studies with mice, where all the
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1 variables are controlled, that at the end of that,
2 those types of studies, lab studies, that the -
3 there's no more higher incidence, is my understanding,
4 of lung cancer through those studies in mice that were
5 exposed to smoking and mice that weren't exposed to
6 smoking.
7 Because of that, as I understand this
8 scientific discipline, there's an absence of that kind
9 of confirmative proof or the mechanism and what have
10 you, so that cigarette smoking stands as a risk
11 factor, which means it may cause these diseases. But
12 it wasn't as you characterized that I said it doesn't.
13 I said that it may.
14 Q. It's fair to say, Mr. Schindler, that the
15 technical people at Reynolds and you disagree with the
16 Surgeon General warning that smoking causes lung
17 cancer; correct?
18 A. We believe that it may.
19 Q. Okay. Isn't that the equivalent of
20 saying I don't know whether it causes lung cancer?
21 It may, maybe it does, and maybe it
22 doesn't, so therefore, your answer is, you don't know
23 whether it causes lung cancer, smoking; correct?
24 A. As I've testified up until now, I believe
25 it's a risk factor and therefore that it may. The
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1 mechanism is exactly how it may work to confirm
2 whether or not it does hasn't been established and
3 therefore it may.
4 Q. And - but I asked you a new question.
5 I've heard you say repeatedly that cigarette smoking
6 may cause cancer.
7 My new question to you is, isn't that the
8 equivalent of saying you don't know if cigarette
9 smoking causes lung cancer when you say it may?
10 A. I think - when I say it may, I think
11 it's - what that means is that it may cause it, it may
12 not, but - it's both of those.
13 Q. What is your company doing to determine
14 whether less tar is safer than more tar in cigarettes
15 from a health standpoint?
16 A. What do you mean? In terms of research
17 or --
18 Q. Anything. Anything.
19 I mean, isn't that the question that the
20 consumer has, in your judgment, if I smoke Now I'm
21 getting less tar, if I smoke More I'm getting more tar
22 and I want it know if less tar is safer for my health.
23 And I'm simply asking you what, if
24 anything, is Reynolds doing to answer that question?
25 MR. WEBER: Object to the form.
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1 Go ahead.
 2 A. You're asking me is Reynolds doing any
 3 research to differentiate levels of risk between low
 4 tar cigarettes and higher tar cigarettes, is that what
 5 you're asking me?
 6 Q. I'm asking you what Reynolds is doing to
 7 help consumers answer the question as to whether less
 8 tar is safer than more tar?
 9 A. I do not know - I mean, I don't know how
 10 to answer that exactly in the sense of your question.
 11 What do you mean by what are we doing?
 12 Q. In terms of answering - are you doing any
 13 research or anything to help answer that question,
 14 whether less tar is safer than more tar?
 15 A. I don't know of any research that
 16 Reynolds is doing relative to that question.
 17 I believe that there are people in the
 18 public health community or medical researchers that
 19 are, I imagine, are looking at that and are people
 20 continually involved in reviewing the literature and
 21 to what degree there's research going on around that,
 22 that they would be knowledgeable of that.
 23 I do not know of any specific research
 24 that we have going on relative to that. I mean, that
 25 type of research, not being a scientific, but that
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1 would seem to me to be long-term epidemiological types
 2 of research.
 3 So our scientists would study literature,
 4 things that are published, if anybody's doing work on
 5 that.
 6 I do not know of any research that we are
 7 doing relative to that question.
 8 MR. WEBER: Stanley, we've been going I
 9 think just an hour now. If you want to find a
 10 break point.
 11 MR. ROSENBLATT: Within five minutes.
 12 MR. WEBER: Thank you very much.
 13 Q. (By Mr. Rosenblatt) As the president and
 14 CEO of R.J. Reynolds Tobacco Company, is your
 15 paramount responsibility to your stockholders, to your
 16 employees, to who?
 17 A. No.
 18 I think we have responsibility to our
 19 shareholders, responsibility to our employees,
 20 responsibility to our smokers, our consumers, to
 21 deliver products that meet their needs, responsibility
 22 to the communities that we work in, be good corporate
 23 citizens. I think a public corporation has a number
 24 of responsibilities.
 25 Q. What is a document called A Frank
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1 Statement To Cigarette Smokers?
 2 Have you seen that document?
 3 A. I've seen it one or two times before.
 4 Q. And what does it mean to you?
 5 MR. WEBER: Let me object.
 6 What does the document as a whole mean?
 7 Q. The significance of it?
 8 You've read it.
 9 A. Well, I've only seen it briefly a couple
 10 times before so if you're going to ask me to comment
 11 on the meaning of something I've only seen for a few
 12 minutes weeks or months ago, I would prefer to see the
 13 document.
 14 Q. Yes. I will - I'll be happy to hand it
 15 to you, you know, after the break.
 16 All I'm asking you now is from a general
 17 or generic standpoint when - in the tobacco industry
 18 when this - as you know, it was a full page ad in many
 19 newspapers, a - called A Frank Statement To Cigarette
 20 Smokers generally, generically, what was the import or
 21 the significance of A Frank Statement To Cigarette
 22 Smokers?
 23 MR. WEBER: Same Objection.
 24 Go ahead.
 25 A. I - you're asking me to comment on a
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1 statement or ad or document that was back in the '50s
 2 as I recall, that I've seen for a few minutes a couple
 3 times in the past.
 4 With that in mind, I will give you my
 5 point of view as to what I remember, I think it meant.
 6 And my take on it when I saw it was, that
 7 the industry was committing research dollars to study
 8 the whole issue of smoking and health.
 9 (Whereupon, the above referred to document
 10 was marked as Plaintiff's Exhibit No. One for
 11 Identification.)
 12 MR. ROSENBLATT: Let's take a break.
 13 (Whereupon, a short break was taken.)
 14 Q. (By Mr. Rosenblatt) Okay.
 15 Mr. Schindler, at the time of the break I was asking
 16 you some general questions about A Frank Statement To
 17 Cigarette Smokers. A couple of minutes ago I handed
 18 you - did you mark it as Plaintiff's Exhibit A or One
 19 - Plaintiff's Exhibit One.
 20 And have you had time to go through that?
 21 A. I really need a couple minutes because I
 22 just kind of glanced at it.
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1 Q. Sure. Go ahead. Take a couple minutes
 2 and do that.
 3 MR. WEBER: Stanley, can I ask, is this
 4 some kind of re-typed print or version?
 5 Because it's got some misspellings on it that
 6 I've never seen in any of the originals I've
 7 seen over on the years.
 8 Is this something - like the one Susan is
 9 looking at there is the one I recognize.
 10 Is this like a re-typed version?
 11 MS. ROSENBLATT: Yes.
 12 MR. WEBER: Because there are some --
 13 MR. ROSENBLATT: Other than the
 14 misspellings, each and every word --
 15 MR. WEBER: You will represent then for
 16 the record that what you intend this to be is
 17 an identical copy of the actual frank
 18 statement, but this is not that.
 19 MR. ROSENBLATT: Correct.
 20 MS. ROSENBLATT: And we can substitute
 21 and enlarge this one later on if there's a
 22 problem with this.
 23 MR. WEBER: Okay.
 24 A. Okay.
 25 Q. (By Mr. Rosenblatt) Okay. You've read
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1 it.
 2 Is it fair to say, Mr. Schindler, that on
 3 the couple of other occasions you've looked at this
 4 document, A Frank Statement To Cigarette Smokers,
 5 you've never in the past read it as carefully as you
 6 have just now?
 7 A. No, it's not fair to say that.
 8 Q. So, in other words, on the other
 9 occasions you've read it just as carefully?
 10 A. Well, I've read it, yes.
 11 Q. Okay. How did this come about?
 12 What is A Frank Statement To Cigarette
 13 Smokers, in terms of the public?
 14 A. How did it come about?
 15 Q. Yes.
 16 A. Well --
 17 Q. Well, how or why did it come about?
 18 A. Can you give me - I don't think it's on
 19 here - the date it was back in the '50s, I believe?
 20 Q. Correct. I can give you the date and the
 21 - I believe that it was published in newspapers in
 22 January January, 1954.
 23 A. '54.
 24 It's difficult for me to say how this
 25 came about. I was not there. I was ten years old at
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1 the time. So I wasn't with the company or obviously a
2 part of the company when this took place, so I'm not
3 sure I can say to you how this came about--

4 Q. Okay.

5 A. -- in any definitive way.

6 Q. No.

7 My understanding is, and I'm going to
8 certainly say this to the jury in this case, that I
9 consider A Frank Statement To Cigarette Smokers to be
10 one of the seminal documents in the whole smoking and
11 health controversy over the years.

12 Do you consider it to be an important,
13 seminal, significant, fundamental document?

14 A. I'm in no position to make that judgment.

15 Q. Okay.

16 A. There's so many documents it's hard for
17 me to --

18 Q. I think it's fair to say that this Frank
19 Statement To Cigarette Smokers came about as the
20 result of certain research, scientific research that
21 was published.

22 Do you know what scientific research this
23 was intended to address?

24 A. I do not know.

25 Q. Okay. Do you know - I'm not asking you
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1 the names of newspapers or other publications where
2 A Frank Statement To Cigarette Smokers appeared in
3 January, 1954, but do you have any sense of how widely
4 advertised it was at the time?

5 A. No, I don't.

6 Q. Okay. Now, we've - I've told you this
7 was published in January of 1954.

8 As you have read this document, is it
9 fair to say that the sentiments expressed in A Frank
10 Statement To Cigarette Smokers are essentially the
11 same today of, for example, your company?

12 And if you want me to go get specific,
13 I'll be happy to do so.

14 A. Well, I'd like you to get a little more
15 specific with the word sentiment.

16 Q. Okay. In this first column toward the
17 bottom there's a statement, quote, we believe the
18 products we make are not injurious to health.

19 A. Yes.

20 Q. You stand by that statement today, don't
21 you?

22 A. Well, this is a statement that was made
23 in 1954. Again, I was nowhere near being involved in
24 this company, so my --

25 Q. When you --
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1 A. When you say do I stand by that
2 statement; I believe earlier in testimony I said that
3 cigarettes are a risk factor and they may cause the
4 diseases that - or some of the diseases that are
5 associated with smoking. So that's my view of how I
6 feel today.

7 Q. But I'd really appreciate a direct
8 question - a direct answer to a direct question and
9 then, you know, elaborate all you want.

10 And my question to you, Mr. Schindler,
11 is, do you believe the products made by R.J. Reynolds
12 Tobacco Company today are not injurious to health?

13 A. Well, as I've said before, I believe they
14 may be. They may be - they are a risk factor and they
15 may cause the diseases that are associated, but it's
16 not clear or determined scientifically that they do.

17 Q. Now, in the second column --

18 A. Up here?

19 Q. I think right about there.

20 A. All right.

21 Q. The second paragraph, quote, regardless
22 of the record of the past, the fact that cigarette
23 smoking today should even be suspected as a cause of a
24 serious disease is a matter of deep concern to us.

25 Does that sentence accurately reflect
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1 your sentiments as president and CEO of R.J. Reynolds
2 Tobacco Company?

3 MR. WEBER: Before we go ahead, let me
4 object because I'm not sure that's a direct
5 quote from the frank statement.

6 We may want to check that as part of that
7 point I made earlier, Stanley.

8 Q. Regardless of the record of the past, the
9 fact that cigarette smoking today should even be
10 suspected as a cause of a serious disease is a matter
11 of deep concern to us.

12 MR. WEBER: So it is.

13 MR. ROSENBLATT: It is. It's exact.

14 MR. WEBER: Okay. Sorry. I know this is
15 testimony you're concerned with given what you
16 said a moment ago in terms of something you
17 believe is important. I just wanted to make
18 sure we've got it accurately and we're working
19 off a proxy document.

20 Q. (By Mr. Rosenblatt) Now, my question to
21 you is, that statement I just read reflects accurately
22 today your position as president and CEO of R.J.
23 Reynolds Tobacco Company, doesn't it?

24 A. No.

25 My position today, as I've stated several
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1 times in this deposition, is that cigarette smoking is
2 a risk factor for a number of diseases and therefore,
3 that means that it may be a cause of these disease and
4 that there's work needed to - into the whole issue.

5 So I -- That's my point of view.

6 Q. Okay. As you read the document, A Frank
7 Statement To Cigarette Smokers, and this is being
8 published in newspapers to the American people and
9 obviously it's addressed to cigarette smokers;
10 correct?

11 That's your understanding of this
12 document?

13 A. It was published in, I guess, newspapers
14 and magazines, I'm assuming that, that it's a
15 statement to the American public.

16 Q. Okay.

17 A. Which would include smokers.

18 Q. And you would agree - well, the - not to
19 get picky, but the statement is not addressed to
20 nonsmokers, it's addressed to cigarette smokers, the
21 title of it?

22 A. Yes.

23 Q. Okay. Now, you would agree that as you
24 read the document in its entirety, one of the
25 fundamental promises that the signators to the
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1 document are making to the American smoker is, we're
2 going to spend a lot of money researching the question
3 of whether cigarette smoking causes disease; correct?

4 MR. WEBER: Let me object for misstating
5 what it says.

6 Go ahead.

7 Q. That's not word for word, but the
8 document taken as whole, you would agree, would you
9 not, Mr. Schindler, that the promise being made to the
10 American smoker is, we're going to spend a whole lot
11 of money through the Tobacco Industry Research
12 Committee to explore the question of whether our
13 products, cigarettes, cause disease; is that correct?

14 MR. WEBER: Same objection.

15 Go ahead.

16 A. It - to me what it says is, is that
17 resources are being pledged to do research into areas
18 that are scientifically related to the health risks
19 associated with smoking.

20 Q. And that's what the tobacco industry is
21 still doing today, isn't it, through the Council for
22 Tobacco Research?

23 A. We give money to the Council for Tobacco
24 Research, the industry does, to do basic research into
25 those diseases that are associated with smoking.

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Q. Basic research, meaning, it's your understanding that the Council for Tobacco Research is funding scientific studies into what are the underlying causes of lung cancer and other diseases; correct?

A. Basic - I am not a scientist, as you well know. Basic research to me means that - this is totally up to the scientific advisory board that is set up to fund projects - is that basic research is into, for example, the causes of cancer, which ultimately could lead to cancers related to smoking, but basic research into cancer, for example.

Q. What is your understanding today in April of 1997 what conclusions have been reached on that subject?

A. I'm --

MR. WEBER: Let me object.

A. I don't understand your question.

Q. The basic causes of cancer.

MR. WEBER: Conclusion --

Do you want to clarify by whom, Stanley?

Q. Yes. By all this research that's being done.

A. I'm not a scientist. I don't feel

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capable for stating the basic causes of cancer.

Q. Yes. I'm certainly not asking it to you from a technical standpoint.

Is it your understanding as a very well informed layman that the causes of cancer in 1997 are they still a mystery or do we know something?

A. I don't - Mr. Rosenblatt, I'm not a scientist. Things that I hear and read in the broad category of cancer, people write about genetic predisposition, they write about environmental factors, they write about lifestyle factors related to diet and all sorts of things, but - so I don't - you know, beyond that, I don't know how else to answer your question, not being a scientist.

Q. Is it your understanding that those questions are still being researched today?

A. The causes of cancer?

Q. The causes of cancer?

A. It is my understanding that the scientific community is still doing a tremendous amount of research into the causes of cancer.

Q. Well, more specifically, is it your understanding that the Council for Tobacco Research as well as your own company is researching the basic causes of cancer?

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A. The Council for Tobacco Research that we give money to has a scientific advisory board made up of some eminent medical researchers and scientists around the country that take project requests from researchers and scientists and decide among themselves as to which research to fund and that research is dealing with in addition to other things, I'm sure, the causes of cancer.

Q. Pretty much the same situation as was expressed in A Frank Statement To Cigarette Smokers, they wanted to do research then back in 1954 and we're still doing research today; right?

MR. WEBER: Objection as to form.

Go ahead.

A. I can talk to today that the research and how the Council for Tobacco Research works with eminent scientists on the scientific advisory board that has control - total control over how this money is distributed for research grants that are proposed to them into the causes of disease, cancer obviously being one of them, in terms of how they allocate those resources and make their judgments about projects.

Q. Is cigarette smoking a possible cause of lung cancer?

A. We have --

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MR. WEBER: Let me object. Asked and answered.

Q. You're going to tell me we've discussed that.

It's a very direct simple question, Mr. Schindler.

Is cigarette smoking a possible cause of lung cancer?

MR. WEBER: Same objection. Asked and answered.

Q. Go ahead.

Never asked and never answered.

A. As we have discussed before, I believe that cigarette smoking is a risk factor for lung cancer and other diseases associated with smoking.

And as I have said before, to me that means that it may be a cause.

Q. So it's a possible cause?

A. I'm saying it's a risk factor for these diseases, and it may, it may not be.

Q. Is cigarette smoking a probable cause for lung cancer?

A. I believe that it's a risk factor.

Q. Is there any more significant risk factor for lung cancer than cigarette smoking?

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A. I don't know.

Q. You mentioned that your father was a smoker?

A. Yes.

Q. Is he living?

A. No, he's not.

Q. Okay. How heavy of a smoker was he?

A. He smoked when he was a smoker, as near as I recall, probably two and a half, three packs a day.

Q. And there came a time in his life when he quit smoking?

A. Yes.

Q. And why did he quit smoking?

A. He went to a doctor - he was having circulation problems, the doctor diagnosed, and he went to the doctor and the doctor told him - he said, Dick, I happen to be with him when this happened, this is somewhere in the early, mid '60s, he said, you can either stop smoking or I can cut off your hands and feet some day. And my father stopped smoking. At the time he was 47 or 48 years old.

Q. Do you know whether or not the doctor diagnosed his condition as something called Buerger's disease?

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A. I don't know if that was the term.

I just remember that that encounter in the doctor's office.

Q. Okay. And other than your knowing it was a problem with circulation, do you know any more detail than that?

A. No, I don't.

Q. And your father passed away at what age?

A. He was 69.

Q. Did he ever smoke again --

A. No, he didn't.

Q. -- after that encounter with the doctor?

A. No, he didn't.

MR. WEBER: Andy, just be careful. Make sure he's finished with the question. That time you started to answer and he was in the middle of it.

THE WITNESS: Okay.

Q. Did you have an understanding then or did the doctor explain what it was about smoking that if your father continued was going to cause amputations?

A. No, I don't. I don't remember any other - anything else other than what I've told you.

Q. Are you married?

A. Yes, I am.

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1 Q. Does your wife smoke?
 2 A. Yes, she does.
 3 Q. How heavy a smoker is she?
 4 A. Oh, my wife smokes a pack a day.
 5 Q. What did your father die from, what
 6 condition?
 7 A. He had a stroke and within a year, year
 8 and a half after the stroke he died of a variety of
 9 complications. I'm not exactly sure the precise thing
 10 at the point he died, but he had a stroke and a year,
 11 year and a half later he died.
 12 Q. When your father had that encounter that
 13 you've described with the doctor, that was a pretty
 14 shocking, unusual kind of episode, wasn't it?
 15 A. It had an impact on him?
 16 A. He stopped smoking.
 17 Q. He had been a heavy smoker for years and
 18 after hearing the doctor say that he stopped?
 19 A. As I mentioned earlier, he had - he was
 20 smoking as I recall two and a half to three packs a
 21 day, he had that encounter with the doctor at age 47,
 22 and he never smoked again, that I know of.
 23 Q. Did he have any difficulty quitting?
 24 A. I don't recall. We're back 30 some years
 25 ago.

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1 All I remember is, that he stopped
 2 smoking and never smoked again.
 3 Q. And you don't remember any problems that
 4 he had?
 5 A. I don't recall any. It's a long time
 6 ago.
 7 I know he never smoked again.
 8 Q. Did your wife ever quit?
 9 A. She quit once, that I can recall.
 10 Q. For how long?
 11 A. I think it was for like three years or
 12 so. I'm not totally sure of the time frame that
 13 she quit. It was about for three years, as I recall.
 14 Q. But, I mean, this was during the
 15 marriage?
 16 A. Yes. Yes, as we've been together a long
 17 time.
 18 Q. Do you remember why she quit?
 19 A. She decided she didn't want to smoke any
 20 more. She quit.
 21 Q. But why?
 22 I mean, did she have a cough or a cold
 23 or --
 24 A. I don't recall.
 25 I mean, you're asking me has my wife ever

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1 quit smoking and I said yes, she did. As I recall, it
 2 was for a period of three years.
 3 Q. Well, didn't you say to her something
 4 like, you know, Honey, you've been smoking X number of
 5 years and I notice you're not smoking any more, how
 6 come?
 7 A. It was her decision. She stopped
 8 smoking.
 9 Q. I understand that.
 10 But I assume you're a normally curious
 11 guy and your wife smokes a pack a day for X number of
 12 years and one day she stops smoking and you don't say
 13 to her how come you're not smoking any more?
 14 A. I don't recall saying to her how come
 15 you're not smoking any more.
 16 Q. And I'm sure when she started smoking
 17 three years later you didn't ask her how come you're
 18 starting again?
 19 A. No.
 20 She's an adult and I assume she was
 21 making her own decisions.
 22 Q. And, Mr. Schindler, whether it's children
 23 or wives or siblings, you take a totally hands off
 24 policy as long as someone's an adult; if they want to
 25 smoke, fine, they don't want to smoke, fine?

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1 You're Mr. Hands Off?
 2 MR. WEBER: Let me object to the form o
 3 the question.
 4 A. With regard to my wife, who is an adult
 5 that is fully knowledgeable, informed as to the risks
 6 associated with smoking, I think she's perfectly
 7 capable of making a decision.
 8 Q. How can should be fully knowledgeable,
 9 Mr. Schindler, if she listens to you who says smoking
 10 may cause lung cancer and it may not cause lung
 11 cancer?
 12 After hearing that, how am I
 13 knowledgeable?
 14 Because I don't know whether it causes
 15 lung cancer or doesn't cause lung cancer, after
 16 listening to you.
 17 MR. WEBER: Let me object to the form.
 18 Again, I'm confused.
 19 A. Me, too.
 20 Could you ask these questions again?
 21 Q. Be happy to.
 22 You're saying your wife is fully
 23 knowledgeable.
 24 And I'm saying if your wife were to ask
 25 you does cigarette smoking cause lung cancer, your
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1 answer is, well, Sweetheart, it's a risk factor, maybe
 2 it does and then again maybe it doesn't.
 3 So hearing that answer, how is she fully
 4 informed as to whether it does or whether it doesn't?
 5 MR. WEBER: Same Objection.
 6 Go ahead.
 7 A. My wife is an intelligent adult that
 8 lives in our society, is aware of Surgeon General's
 9 reports, is aware of warning labels on packs and ads,
 10 is aware of everything that is written continually
 11 about cigarettes. I think she is aware of as almost
 12 anybody in our society of the risks associated with
 13 smoking. She's a fully informed adult, capable of
 14 making her own decisions.
 15 Q. You would agree, would you not,
 16 Mr. Schindler, that if someone accepts your view that
 17 maybe cigarette smoking causes lung cancer and maybe
 18 it doesn't, that as a fully informed individual
 19 obviously it's a gamble, if they smoke, maybe they
 20 will get lung cancer as a result of smoking and maybe
 21 they won't?
 22 And what you're saying, as I understand
 23 it is, that's the adult choice, whether you choose to
 24 take that gamble; isn't that correct?
 25 A. As I've said before, I believe that
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1 cigarettes are a risk factor for these diseases. I
 2 believe therefore that they may cause them or they may
 3 not.
 4 I believe the public health people in
 5 this country, the scientists and doctors, have
 6 published vast amounts of data, information, the medi
 7 has certainly covered this whole issue.
 8 It is inconceivable to me that someone,
 9 including my wife, that would not be informed on the
 10 risks associated with smoking. And that when she or
 11 anyone makes a choice to smoke or when I make a choice
 12 to smoke that I am doing it fully aware of what the
 13 risks are associated with the product.
 14 Q. When your father had the episode with the
 15 doctor that you've described, you were how old then?
 16 A. This was - 19 or so, 19, 20, as I recall.
 17 Q. You were a smoker by then?
 18 A. Yes.
 19 Q. After that episode did your father tell
 20 you don't smoke or did he tell you, Andrew, it's an
 21 adult decision, if you want to smoke, smoke?
 22 A. I can't remember my dad telling me not to
 23 smoke after that. We're talking 30 some years ago. I
 24 just don't remember that encounter.
 25 Q. Did either of your parents ever express
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1 an opinion to you when you started smoking and when
2 they realized that you were in fact a smoker that this
3 is something you should not do, or that it displeased
4 them in some way, the fact that you had become a
5 smoker?

6 A. I can't remember specific - we're going
7 back 30 some years. I can't remember a specific
8 encounter when my parents said don't smoke.

9 I imagine they probably made some
10 comments, but I don't specifically remember them.

11 Q. Do you have children?

12 A. Yes, I do.

13 Q. Do they smoke?

14 A. One daughter does.

15 Q. How many kids do you have?

16 A. Two girls, two daughters.

17 Q. Ages?

18 A. Twenty-three and 20.

19 Q. One smokes and one doesn't?

20 A. Twenty-three year old smokes.

21 Q. Was there ever a discussion as to why one
22 made that choice and one made the no smoking choice?

23 A. Well, at one point they both smoked. Now
24 only one of them smokes. The oldest, the 23 year old
25 smokes.

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1 Q. The 20 year old smoked for awhile and now
2 she's become a nonsmoker?

3 A. Right.

4 Q. Did she ever discuss the reasons why she
5 became a nonsmoker?

6 A. No. She stopped smoking.

7 Q. What age did your daughter start smoking?

8 A. Well, when they were I guess in that 16
9 year old range they started sneaking cigarettes and my
10 wife and I sat them down and told them that they
11 shouldn't be smoking, that they weren't old enough to
12 make that decision, that there are health risks
13 associated with smoker and that they better knock it
14 off until they become legal age to smoke or to buy the
15 product. The same discussion we'd have about underage
16 drinking.

17 So in terms of when did they actually
18 become smokers, as far as I know, it was probably at
19 around 18 or so.

20 I know they snuck cigarettes and things
21 of that nature, and we sat them down and talked to
22 them about it.

23 Q. So the only time that you ever really
24 took a position on smoking is as it relates to age; in
25 other words, if someone is 18 or over your point of
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1 view is, that's an adult decision whether they choose
2 to smoke or not smoke is that decision, but if
3 someone's under the age of 18 and you have any control
4 or input in the situation, you will try to influence
5 them not to smoke?

6 MR. WEBER: Let me object to the form.
7 You can answer.

8 A. Could you ask this question again,
9 please?

10 Q. No.

11 MR. WEBER: He couldn't if he tried.
12 (Thereupon, the requested portion of the
13 record was read back as above recorded.)

14 A. There's a lot in that question.

15 Could you --

16 Q. Yes.

17 As I've understood your testimony, you
18 know, so far today, I asked you a hypothetical about a
19 friend and other things have come up, my understanding
20 is, that your point of view is, if you're an adult
21 whether you smoke or don't smoke is entirely your
22 adult decision and I, Mr. Schindler, am not going to
23 interfere or on attempt to have input. The only time
24 you will try to have input is if someone is under what
25 you consider to be the age to make an adult choice?

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1 MR. WEBER: Let me object to the form.
2 Again, you can answer.

3 A. If somebody's 21 years old or 45 years
4 old or 35 years old and they ask me my point of view
5 about smoking and risks associated with smoking, I
6 would talk freely to them about it, like we're talking
7 here today.

8 If I encounter, as I did with my
9 daughters, somebody who is underage, I will certainly
10 assert myself into my daughter's life if they're doing
11 something that I believe is inappropriate.

12 And I would be the same way about
13 alcohol. If a daughter under age is drinking, I would
14 have the same point of view.

15 So your characterization that I would
16 never talk to anybody as long as they're of legal age
17 is simply not correct. But if somebody's 25 years old
18 or 40, for me to inject myself into their life I think
19 is inappropriate. If they ask me my point of view I
20 would certainly share that with them, as I have with
21 you here today.

22 Q. Does involuntary smoke cause lung cancer
23 or any other disease?

24 A. You're talking about ETS, environmental
25 tobacco smoke, secondary smoke?

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1 Q. Well, I call it - I'll tell you --

2 My definition of involuntary smoke - if I
3 as a nonsmoker am sitting in this room and two or
4 three people are smoking, I'm being forced
5 involuntarily to take in some of that smoke. So I'm
6 talking about a nonsmoker who's in a situation where
7 there's other people with cigarettes and some of that
8 smoke comes into the nonsmoker.

9 So my question is, does involuntary
10 smoke, secondhand smoke, passive smoke, whatever you
11 wish to call it, does that kind of smoke cause lung
12 cancer or any other disease?

13 MR. WEBER: Let me object to the speech
14 prefacing the question, but go ahead and
15 answer.

16 A. You're asking me do I believe that
17 secondhand smoke causes lung cancer, is that the
18 question?

19 Q. Correct.

20 A. I don't believe it does. I don't believe
21 that the epidemiology, as I understand it, and talking
22 to our scientists points in that direction. I don't
23 believe there's any - been any epidemiology that
24 points to secondhand smoke being a cause of lung
25 cancer. And based on that scientific data that has
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1 been done up to this point, I don't believe it does.

2 Q. So your position on involuntary smoke is
3 different than your position on active smoking,
4 correct, as I've just heard your answer?

5 A. My position on active smoking is that the
6 epidemiology has established smoking as a risk factor
7 for certain diseases.

8 And my position on ETS or secondhand
9 smoke is that the epidemiology, as I understand it,
10 and talk with our scientists, does not establish that
11 as a risk factor.

12 Q. Have you read the Surgeon General's
13 report of 1986 or any part of that report?

14 A. No, I haven't.

15 Q. Have you read the EPA report of 1993?

16 A. I have not read the report. I have had
17 briefings and discussion on it and read things, you
18 know, that were reported in newspapers and so forth.

19 Q. Well, the - according to the EPA,
20 secondhand smoke is a Class A carcinogen.

21 On what basis do you say it's not?

22 A. On the basis that the epidemiology that
23 has been done to this point collectively on secondhand
24 smoke, the summary of the studies, those included in
25 the EPA and the research done since then has - if
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there's essentially - if one no risk, its cumulative risk is 1.04.

When the EPA issued their judgment that ETS or secondhand smoke was a Class A carcinogen, they had excluded one study, as I understand it, and they had a 1.19 in their methodology.

The research has continued and it's now down to 1.04.

I believe there are studies of males in the work place or something like that has a statistical risk of .97, which means in that case that it's even less.

And in my understanding and in talking to our scientists as epidemiology develops over time and the number keeps coming down, that it points in the direction of it not being a risk factor.

I also understand in terms of other epidemiology studies, things related to diesel fumes, studies related to high tension wires that had risk of three times, for example, the EPA would say no, that's not enough data.

So on very low statistical data, data that has gotten even smaller and smaller relative to risks percentages, the EPA made a judgment on cigarette smoke that was counter to other things they

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had done in the past, including studies that I understand that there was risk relative to 1.65 on caffeine and heart disease and they declared it was not relevant enough to make any judgment - or make any judgments there.

So it seems to me and what I've discussed with our scientists in trying to understand this that the statistical data moves away and has continued to move away from this judgment that the EPA made.

One of the scientific advisory board members that was I believe at the press conference made the statement that the people in the room - this is from the EPA scientific advisory panel, that the people that came to that press conference were at greater risk in driving through the overall environment of Washington than they were from secondhand smoke.

Stanley Glantz, in San Francisco, made the statement you're at greater risk of not using your seat belt.

The Congressional Research Service, that studied this independently, concluded that there was not data here to justify the judgment that the EPA made.

So in looking at all of that and talking

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on our scientists, it is my feeling that saying that secondhand smoke causes lung cancer, there's absolutely no proof for it.

Q. Are you familiar with the Hierama (phonetic) study?

A. No, I'm not.

Q. Have you ever in your life read any epidemiology study?

A. No, I haven't.

Q. What is epidemiology?

A. It's a medical science that studies statistical relationships around certain diseases by interviewing people and tracking groups of people over time.

Q. I want you to assume that Norma Broin, who is a lead flight attendant in the Broin class action, was brought up in Utah, never smoked, was never around smoke until she became a flight attendant, and she worked as flight attendant for a number of years and developed lung cancer. And I want you to assume that her doctors, as well as one of the most knowledgeable pulmonologists in the world, who have reviewed her records, say that her lung cancer was caused by her exposure to secondhand smoke in airline cabins.

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What is your basis for disagreeing with that assessment?

MR. WEBER: Let me object to the form. You can answer.

A. My understanding of the epidemiology that has been done before, during and after the EPA judgment is, that it does not demonstrate cigarette smoking is a risk factor for lung cancer.

Q. What caused Norma Broin's lung cancer?

A. I have no idea.

MR. WHITING: Excuse me. Mr. Schindler, I believe you just said that the evidence doesn't say that cigarette smoking is a risk factor.

Did you mean exposure to cigarette smoke?

A. Exposure to secondhand smoke or ETS is a risk factor.

Q. Your company sued the United States Environmental Protection Agency; isn't that correct?

A. Several companies in this industry filed a suit against the EPA and their judgment of secondhand smoke as a Class A carcinogen.

Q. Be that as it may, Reynolds sued them; right?

A. Yes.

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Q. Okay. What's the status of that lawsuit?

A. It's - all I know is that it's still in the court. I don't know the status beyond that.

Q. And the reason you sued them with your Fellow tobacco companies was, because their report hurt your business; correct?

A. No.

Q. Then why did you sue them?

A. Because we believe they were wrong in the judgment that they made.

Q. Where did you sue them?

A. I believe that's in a court in Greensboro, North Carolina.

Q. One of the reasons you sued them, the United States Environmental Protection Agency, was because a tremendous number of buildings and government facilities banned smoking; correct?

A. That's not my understanding.

I believe we sued them because we felt that the judgment that they had rendered with regard to secondhand smoke was incorrect and wrong.

Q. You would agree, would you not, that you have learned that since the EPA report came out thousands of buildings in this country, hundreds of municipalities have banned smoking in their

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facilities, such as the United States Defense Department?

I mean, you're aware of that, aren't you?

A. And prior to the EPA report thousands of buildings and communities and so forth had put restrictions in with regard to smoking.

Q. Were doing it. Okay.

And more - after the EPA report, more followed; correct?

A. I suppose that's true.

Q. How come they don't get it?

How come the only people who aren't satisfied that the findings of the Environmental Protection Agency and the Surgeon General and the medical and scientific communities on the issue of passive smoke, the only industry that questions that repeatedly and over and over again is the tobacco industry?

MR. WEBER: Let me object to the form.

You can answer.

A. I'm not sure what you're asking me.

Q. Yes.

I'm asking you, obviously the people who banned - had the power to ban smoking in buildings, in the defense department, in airlines, in governmental

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1 agencies, have concluded that environmental tobacco
2 smoke is a danger to nonsmokers.
3 And my question is, how come the only --
4 A. I have no --
5 MR. WEBER: Wait. Let him finish his
6 question, because he hadn't finished it yet.
7 Q. How come the only group in this society
8 who hasn't accepted that, that environmental tobacco
9 smoke poses a danger to nonsmokers, is the tobacco
10 industry?
11 MR. WEBER: Object to the form. iGo
12 ahead and answer.
13 A. I have no idea if that's why any given
14 company or governmental agency eliminated smoking in
15 their work areas, because they've concluded that it's
16 dangerous.
17 I don't know what - if that was - what
18 degree that was part of their decision, pressure from
19 employees. There are a variety of reasons. And it's
20 impossible for me to discern all the judgments that
21 people have made.
22 And in the same time frame people have
23 accommodated smokers and nonsmokers in their work
24 areas. Other people have made judgments to eliminate
25 smoking.

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1 And I have no idea if all these different
2 people have made this judgment on this notion of
3 danger that you've put out here in this manner.
4 Q. You don't think it's clear that generally
5 speaking the reason why the United States Defense
6 Department, many governmental agencies and entities,
7 many private employers and buildings have banned
8 smoking in their facilities is because they are
9 satisfied that secondhand smoke poses a health danger
10 to nonsmokers; you don't accept that as a general
11 proposition that's accurate?
12 A. I don't. I mean, I don't know. I've not
13 talked to these people.
14 I know organizations that have
15 accommodated smokers in their work environment.
16 Q. You would agree, would you not, that
17 there are no warnings on your cigarette packs that
18 secondhand smoke causes any disease?
19 A. That's right.
20 The warnings on our packs are the ones
21 that exist today by direction of the - our government,
22 legislature, working with the Surgeon General, FTC and
23 so forth.
24 Q. And obviously if that direction was not
25 there, there would be no warnings on any of your

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1 packs?
2 A. It's a theoretical, speculative question.
3 Q. Well, let's - let me ask you this
4 hypothetical question. As president and CEO, you
5 know, you're a decision maker, you're a decisive guy,
6 that's how you got the job, presumably, there's no
7 mandated warnings, as far as the government is
8 concerned, as far as society is concerned, you have an
9 absolute right to put on your packages anything you
10 like. Would you have a health warning?
11 MR. WEBER: Let me object.
12 Do you mean now, Stanley, before?
13 Q. Yes. Now. Today.
14 Would you have a health warning on your
15 Camels and Winston and all the other brands?
16 A. I think this is - it's really a
17 theoretical question.
18 We've had health warnings on packs of
19 cigarettes, on cartons, on advertising placements for
20 over what, 30 years now.
21 Q. Because you were required to.
22 MR. WEBER: Wait. Let him finish his
23 answer, Stanley. Let's be fair here.
24 A. Through a process of public health
25 officials, the industry legislatures agreeing on on

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1 what the social policy of this society would be.
2 What we're created were the warnings that
3 are on the packs, we comply with that, it's there,
4 it's been in our society for 30 years.
5 The whole issue of cigarette smoking has
6 been dealt with in various forms and social policy for
7 years and years in this country.
8 And the theoretical world that says what
9 would you do if nobody was doing any research into
10 cigarettes just doesn't exist. It's been an issue in
11 our society for many, many years, and this is the
12 social policy it's created and we comply with that.
13 Q. This is not a tough question,
14 Mr. Schindler. And if you're - hear me out. If your
15 ultimate answer is I can't answer it, that's your
16 answer.
17 I'm simply asking you, I want you to
18 assume that there are no government mandated warnings.
19 As far as the government is concerned, you can put on
20 your packs of cigarettes whatever you like.
21 And my question to you as the president
22 and CEO of R.J. Reynolds Tobacco Company is, isn't it
23 true, Mr. Schindler, that if you were not required to
24 put health warnings on your packages of cigarettes,
25 you would have no health warnings?

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1 MR. WEBER: Let me object and move to
2 strike the statement at the beginning.
3 Go ahead and answer.
4 A. I don't think that's necessarily true.
5 I think in the world that you're trying
6 to create is a world where you end up with government
7 officials, public health officials, people in the
8 industry resolving this issue for society, and that it
9 would work in this theoretical world if that began
10 today or as it did 30 or 40 years ago. So I - it's
11 inconceivable to me that cigarette smoking issues
12 would be dealt with in a singular, somewhat narrowed
13 discreet way that you described it.
14 I think society, of which which are part,
15 would work and decide what to do with regard to health
16 warnings.
17 Q. If in this hypothetical situation you
18 could put on the packages of your cigarettes any
19 warning you wanted, would your warning say that Camels
20 may cause lung cancer and maybe not; is that what your
21 warning would say?
22 Because that's what I've heard you say
23 repeatedly all day today. May be it does, maybe it
24 doesn't.
25 MR. WEBER: Same objection. That is

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1 object to the form.
2 You can abscond.
3 A. I think in the hypothetical world you
4 have created for this question, that the companies,
5 public health people, Surgeon General, legislators,
6 would work out what the health warnings are.
7 And I don't believe the hypothetical
8 world you create, that somebody independent of that
9 social structure, or social policy issue would ever
10 exist, and it would work out as to what the labeling
11 would be.
12 Q. You're telling me --
13 A. As it did in the past.
14 Q. You're telling us that if you were not
15 required to deal with the Surgeon General and various
16 agencies of government, you would voluntarily seek
17 them out for their input?
18 A. I'm saying that the process that existed
19 in our society, given the issues surrounding smoking,
20 would work its way through the total society in terms
21 of social policy and that that's how you would end up
22 with warning labels, which is what happened, you know,
23 30 some years old. I think that process would happen
24 again.
25 Q. How many smokers quit smoking every year?

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A. I'm not sure. Probably one and a half, two million, a couple million people a year, I suspect.

Q. And obviously I'm not asking you why each and every individual quit smoking. I'm asking you a more general question.

Would you not agree that the great majority of smokers who quit smoking do so because they are worried about the health consequences of their continuing to smoke?

A. I think people quit because of health consequences, I think people have quit because of the cost of the product, I think people quit for a whole variety of reasons.

Q. My question to you is, would you not agree that the majority of quitters quit for health reasons?

MR. WEBER: Objection, asked and answered.

A. I don't know.

I know that people have - who smoke consider, are concerned about the health risks associated with smoking, and that when they decide to quit, people have that somewhere in their equation for quitting, but they have other issues as well. So I'm

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in no position to know what percent of people solely because of health risks concerns, I think that's part of the judgment and to what degree that is total, I really don't know.

Q. Well, don't you think that - although your father's experience may have been unusual in how direct and scary his doctor was, don't you think that it's repeated over and over and over again in doctors offices throughout this country where a doctor tells his patient to quit smoking for health reasons or do you think that's an unusual occurrence?

MR. WEBER: Let me object to the form. Go ahead and answer.

A. Well, I think doctors tell people to quit all the time.

Q. For health reasons; right?

A. Yes.

Q. Okay. You think there are many doctors that are telling patients you know, you look a little nervous today, Jack, why don't you take up smoking?

A. No, I don't.

Q. That doesn't happen, does it?

A. I doubt it. I don't think so.

Q. You wouldn't want that kind of doctor, would you, if there's such a doctor out there that

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would suggest to nonsmokers that they take up smoking? You wouldn't want that kind of doctor, would you?

A. I - that's why - I don't know what to say about that, Mr. Rosenblatt.

Q. Sure you know what to say about that.

A. I don't even know how to begin to answer that.

Q. Sure you know what to say about that.

You wouldn't want to know from such a doctor because he would have very poor judgment in your opinion; correct?

MR. WEBER: Let me object to the form of the question.

A. You asked me if doctors tell patients to quit smoking, and I said yes, they do.

Q. Now, how many - what percentage of smokers who quit smoking have difficulty quitting?

A. I have no idea. Some do, some don't. I have no idea what percentage of smokers who quit smoking have what you call difficulty.

I don't even know what you mean by

difficulty.

Q. I'll tell you my definition of difficulty is a guy or a woman that say to themselves I smoke a pack and a half a day, this is a terrible addiction, I

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think it's going to kill me some day, I have sincerely tried to quit and I can't quit because I'm hooked on the Camels and the Winstons. That's what I mean by difficulty.

A. Have they tried to stop?

Q. Yes. And they can't.

A. Well, 40 some million people have quit smoking. In 1982 the industry sold over 600 billion cigarettes. Today the industry sells 480. Obviously a lot people have quit smoking. My own personal family experience people have quit.

Q. Your daughter?

A. My daughter, my wife, myself, my father, friends I know have quit.

So when you describe difficulty, it's hard for me to exactly know.

Are you talking about being edgy or nervous for a day or two after you quit smoking?

Q. No.

How many of the quitters start again?

You've had a lot of experience with that, too. You quit and you go back.

A. I really don't know.

Q. Now, these products that are on the market, nicotine gum, Nicoderm, you've seen all of

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those, isn't it your understanding that those products are on the market and make a profit because they are directed to people who are unable to quit smoking on their own?

A. Yes.

Q. Is it your view that cigarette smoking is addictive?

A. What does that word mean?

In our society today --

When I grew up as a kid, addiction, you know, back in the '60s, before I was a kid, '50s, '60s, '70s, addiction meant hard drugs, heroin and cocaine, it meant intoxication, it meant unable to control the use of the drug, it meant losing your job, it meant desperate acts to get enough money to buy the product, robbery, burglary. That was - you know, your family could break up. If you wanted to get off of the addiction you had to be committed to some medical institution for some period of time, you went through massive withdrawal.

Today we talk about addiction in everything from, you know, caffeine. I saw a British researcher talking about addiction to carrots, in the Wall Street Journal --

Q. Carrot addiction?

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A. Yes. There was British research that did research on carrots.

And the Wall Street Journal within the last year an article written on the new frontiers of addiction as it relates to chocolate. People talk - frequently in every day language talking about addiction to television, talking about addiction to violent sports.

And it seems to me when you ask me do I believe cigarettes are addictive in that full array --

Q. I have a feeling you're going to say no.

MR. WEBER: Please let him answer without interrupting him.

MR. ROSENBLATT: The tape is going down.

MR. WEBER: It doesn't matter.

MR. ROSENBLATT: It's a long, long and nonresponsive answer.

A. I'm very, very responsive.

MR. WEBER: It's perfectly responsive.

You just don't happen to like it.

MR. ROSENBLATT: I love the answer because he's uptoeing around a very direct a question.

His answer is no, it's not addictive.

And I'm hearing all this about heroin.

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1 MR. WEBER: If you really did like the
2 answer, you would have let him complete it.
3 MR. ROSENBLATT: I love the answer.
4 MR. WEBER: You would have let him
5 complete it. That's the way a trail lawyer
6 deals with an answer he likes.
7 MR. ROSENBLATT: Finish the answer.
8 MR. WEBER: Go ahead.
9 A. So, when you have this broad range
10 definition of addiction, and you say to me are
11 cigarettes addictive, I say to you that cigarettes are
12 like caffeine, not like heroin and cocaine.
13 Q. (By Mr. Rosenblatt) So they're not
14 addictive.
15 Bottom line is, cigarettes are not
16 addictive; correct?
17 A. I don't think the word applies.
18 Q. Okay. So it's not addictive.
19 Is it your view, Mr. Schindler, and I
20 think the tape - maybe we can get this question and
21 answer in - is it your view that any cigarette smoker
22 who has sufficient willpower and determination and
23 really makes up his or her mind can quit smoking if
24 they really want to quit smoking?
25 A. I believe if you want to quit smoking,
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1 you can quit smoking. It's proven by the huge number
2 of people that have quit smoking.
3 Q. And all the people that are using the
4 Nicoderm and the nicotine gum, they just lack
5 character and they're a bunch of weaklings, because
6 they need help and they can't do it on their own;
7 right?
8 MR. WEBER: Objection.
9 A. No.
10 I don't - if they feel that they have the
11 need for nicotine gum or Nicoderm to help them, I
12 think that's fine.
13 But I believe at the end of the day, you
14 know, giving up smoking is driven by your desire to
15 give up smoking.
16 MR. ROSENBLATT: That's it.
17 (Whereupon, a lunch break was taken.)
18
19 Q. (By Mr. Rosenblatt) Mr. Schindler, is
20 Mr. Johnston still with the company?
21 A. No, he's not.
22 Q. Okay. When did he leave?
23 A. He left - he retired in end of June of
24 last year, of '96.
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1 Q. He didn't go into some other business or
2 with some other company, he's retired, as far as you
3 know?
4 A. He's retired, yes.
5 Q. Why do you think that Mr. Lebow admitted
6 that his products cause cancer and are addictive?
7 A. I think you have to ask Mr. Lebow. I
8 have - I don't know why he did that.
9 Q. You don't have any idea on that?
10 A. No.
11 I - you have to ask Mr. Lebow.
12 Q. Well, I'm entitled to ask other people
13 for their opinion of that action.
14 Do you have an opinion as to whether he
15 sincerely believes that?
16 A. Again, I think that's for Mr. Lebow to
17 answer.
18 Q. How much time, if any, did you put in
19 preparing for today's deposition?
20 A. Well, several different sessions. In
21 terms of total time, I don't know, maybe several days
22 over a period of several weeks, couple months or so.
23 Q. You mean these were sessions where
24 several lawyers would have been present with you
25 questioning you or asking you the kinds of questions
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1 they thought I might be asking?
2 A. Well, it was, you know, discussion of
3 issues, questions, getting a sense of how depositions
4 work, since I've never been involved in a deposition
5 before, that type of thing.
6 Q. Were any of the sessions what might be
7 characterized as mock sessions, where you were asked
8 to presume that this was a deposition setting and
9 various lawyers would be asking you questions and you
10 would actually give answers and then they would
11 evaluate your answers?
12 A. Well, there were sessions where I would
13 be asked questions and I would answer them.
14 Q. Who played me?
15 A. Ted Grossman.
16 Q. How did he do?
17 Less obnoxious than I am, or about equal?
18 A. About the same.
19 Q. About the same?
20 A. Ted Grossman is a very competent guy.
21 Q. Now, before the lunch break we were
22 discussing - you talked about the enormous number of
23 smokers who have quit smoking.
24 What has been Reynolds's strategy,
25 marketing techniques as to how to replace those
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1 quitters?
2 Because once someone has quit smoking and
3 presumably if this is a lifelong decision, they're
4 never going to pick up another cigarette, you've
5 obviously lost a customer.
6 So my question is, how do you go about
7 replacing the quitters?
8 A. We don't have any strategy for replacing
9 quitters. The people that quit quit and the people
10 that are smoking are smoking and there's no strategy
11 that we have to replace smokers.
12 Q. Well, with or without a strategy, it's
13 obvious that the replacement smokers come from younger
14 people, isn't it?
15 A. It's - I'm not sure what you mean by
16 replacement smokers.
17 Q. Younger people --
18 A. What are you asking me here?
19 Q. Why do you spend millions upon millions
20 upon millions of dollars in advertising?
21 Isn't part of the reason at least to
22 replace the smokers who quit and the smokers who die?
23 A. We spend money on advertising to try and
24 persuade smokers that are smoking our competitors
25 brands to try our brands. There's no strategy there
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1 to spend money to get what you call replacement
2 smokers.
3 It's to try and persuade a Marlboro
4 smoker to smoke a Camel or a Winston or what have you.
5 Q. But wouldn't you agree that that's a very
6 poor use of money, in that generally speaking the
7 studies show that that ends up pretty much as a wash?
8 A. I don't know what you mean by studies
9 show it ends up as a wash.
10 Our marketing dollars are directed at
11 trying to get competitive smokers to switch to our
12 brands or try our brands.
13 Q. And how do you determine if that's
14 successful?
15 Do you have studies or statistics on
16 that?
17 A. Ultimately we determine that by whether
18 or not you've improved your market share and if
19 whether or not in improving your market share you have
20 gotten competitive smokers to consider your brands.
21 Q. Are you able to give me even a rough
22 estimate as, let's say, the last five years how many
23 Marlboro smokers have switched to Reynolds' products
24 or vice versa, how many Reynolds smokers have switched
25 to Marlboro?
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A. I can't give you a number as to number of Marlboro smokers that may have switched to our brands.

Q. Have you read Mr. Johnston's deposition that was taken a couple years ago?

A. No, I haven't.

Q. I want you to assume that when he was discussing the issue of advertising to get smokers to switch brands, that he said it ends up pretty much as a wash, and I understood him to mean that be as many Marlboro smokers that will switch to Reynolds you'll lose approximately the same amount of smokers going to other brands made by other companies.

Do you agree with that?

MR. WEBER: Object to the characterization of testimony.

If you have it, you ought to show him precisely.

MR. ROSENBLATT: I don't have it right here.

A. I'm not familiar with Jim's testimony.

I would like to see it, if you had it, but I'm just not familiar with that.

I'm telling you that from my point of view that are marketing dollars are devoted to try and get competitive smokers to switch to our brands.

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Q. (By Mr. Rosenblatt) Forget about Jim Johnston's testimony.

My question to you simply is, is it your impression over the years that generally speaking the amount of smokers that come from other lines to Reynolds pretty much equals the number of smokers, the Reynolds smokers that go to other brands, within a five or ten year period, or you just don't know, you just don't have any idea?

A. We've been losing market share, so just broadly in that I would say that apparently it's not even. We've lost market share.

Q. If there were a strategy to replace quitting smokers with people who have never smoked, that would come under the broad general heading of marketing, wouldn't it?

A. There aren't --

MR. WEBER: Objection.

Q. I understand that. You've told me there's no strategy.

Now I'm simply asking you, and I have the right to ask hypothetical questions, I'm simply asking you, if there was such a strategy, I know you've told me there is no such strategy, if there was such a strategy, would that strategy come under the general

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category of marketing?

MR. WEBER: Same Objection.

Go ahead.

A. There is no strategy to use marketing dollars to try and get people to start smoking. It's my view not even possible to do. You're asking a hypothetical question that I just think is simply not feasible.

Q. Let me explain something to you, Mr. Schindler, this may be difficult for you to grasp, the concept of a hypothetical question is that even as you hear the question you may think it's absurd, it's stupid, it calls upon you to assume the facts in the question are true and do your best to answer it.

Will you try to do that in the future?

A. I'll try --

MR. WEBER: Let me object to Mr. Rosenblatt giving you any instructions in how to answer. You answer to the best of your ability.

Just ask him questions.

MR. ROSENBLATT: Well, your instruction and obviously in all these hours of sessions he's been instructed to take the position that any time he's asked a hypothetical question he

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says well, that hypothetical question is just not - I'm just not going to answer it.

He's here to answer questions. But okay.

Q. (By Mr. Rosenblatt) Do you take the position that -- Strike that.

Do you think that any nonsmoker ever drove along a highway, saw one of your ads or saw a Marlboro ad and was attracted to it, people look very happy, they look youthful, they look like they were having a good time, and bought a pack of cigarettes and became a smoker as the result of advertising or is that something you think has never occurred in the history of recorded mankind?

A. I don't believe somebody makes a decision to smoke by looking at a billboard on an interstate.

I believe that smoking is something that is so intertwined in our culture that your decision to smoke or your exposure to the smoking behavior is a function of your social environment, parents, friends, relatives and so forth, and that it is just inconceivable to me that somebody who is not engaged in smoking behavior would be driving down a highway and see an ad and decide because of that ad that suddenly they decide that they're going to smoke. I just find that not conceivable, not reasonable.

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Q. So you're telling me that not --

By the way, how much does Reynolds spend on tobacco advertising in a given year?

A. We spend about one-point - on advertising? About \$100 million.

Q. Has that been the situation for the last five, ten years, about \$100 million per year?

A. It's 70, 80, \$100 million.

Q. Okay. Now, is it your position that none of that \$100 million is directed toward the nonsmoker?

A. Absolutely that's my position.

Q. So 100 percent of your advertising budget is directed toward people who are already smoking a brand, to get them to switch from that brand to one of your brands?

A. It's devoted to trying to get competitive smokers and also at your current smokers to, reinforce their brand of choice. So if somebody a Camel smoker, to reinforce their brand of choice and to appeal - attempt to appeal to competitive smokers.

Q. How could someone prove to you that cigarette smoking causes cancer?

What kind of experiment would satisfy you that for a particular individual the cause of that individual's lung cancer was smoking, where you would

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say no, no, in this guy's case it's not merely a risk factor, I'm satisfied that the cause of his lung cancer is the fact that he smoked three packs a day for 30 years?

A. You're talking about a specific individual as opposed to the population?

Q. Yes. Right.

A. I have no idea what anybody could do or what would need to be done relative to a specific individual.

Q. The reason I'm asking the question is, is because it's been obvious from your testimony that your position is cigarette smoking may cause lung cancer and it may not cause lung cancer, but it is definitely a risk factor for lung cancer.

So I'm saying okay, that's your position.

What would I have to do, what would medical science have to do to prove to you that cigarette smoking caused an individual's lung cancer?

A. I'm not a scientist or a doctor and I don't know in the case of a specific individual what kind of scientific proof or evidence would have to come to bear on a particular individual for it to be proven.

Q. Well, let me try to discuss with you

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causation, not from a real technical standpoint but from a common sense standpoint.

If you were told an individual had cirrhosis of the liver and you were told that that individual had consumed a fifth of vodka every night for ten years, and, you know, otherwise he led a pretty run-of-the-mill, normal life, wouldn't you accept the fact that the cause of his cirrhosis of the liver was the vodka for the ten years or would you need to - would you need to know something about the furniture in his house?

MR. WEBER: Let me object.

Q. As a possible risk factor?

MR. WEBER: Let me object to the form of the question.

Q. You can answer it.

A. Could you repeat the question, please?

(Thereupon, the requested portion of the record was read back as above recorded.)

A. I'm not a medical doctor and my knowledge of cirrhosis of the liver would be rather limited.

In this situation that you're portraying here, I - I might say that maybe or perhaps the alcohol consumption may have had something to do with it, but I don't know. I mean, I - I really have no

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knowledge of that.

Q. Another hypothetical question. A kid starts smoking when he's 15 years of age, smokes two packs a day until he's 41, at age 41 he develops lung cancer, his parents are nonsmokers, they're perfectly healthy, in their 80s, his siblings are all nonsmokers, they're perfectly healthy, this man has a wonderful diet and a stress-free job.

Wouldn't your common sense tell you that the cause of his lung cancer was the two packs of cigarettes for all those years or would you need more information?

A. Mr. Rosenblatt, as I've testified throughout the day about risks associated with smoking, I would say that it may have caused that, it may not have, that it would be a factor related to it, perhaps. But in terms of concluding that that individual's lung cancer specifically came from cigarettes, I would have no way of knowing. It may, given the risks, the known inherent risks in smoking, but it may not have. I have no way of knowing in your theoretical example.

Q. Isn't it obvious to you, Mr. Schindler, that the reason that the tobacco industry takes the position that smoking doesn't cause lung cancer but is

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merely a risk factor for lung cancer is you can continue with this line for the next 100 years and keep selling cigarettes, because there is no way for anyone to ever prove to you that cigarette smoking causes lung cancer?

MR. WEBER: Object to the form.

Q. You can't even come up with a hypothetical situation where you would say okay in that case I'm satisfied the cause of this individual's lung cancer was 30 years of smoking three packs a day, even in that kind of situation you'll say no, I don't accept the cause.

MR. WEBER: Same objection.

A. Could you ask your question again, please?

Q. I don't think I really have to.

With the background I've given you, isn't it obvious that causation by virtue of the structure which the tobacco industry has set up can never be proven here?

You will never accept the fact that cigarette smoking caused a person's lung cancer?

A. Mr. Rosenblatt, I am giving you not an industry position, but I'm giving you my point of view. And I believe that cigarettes - smoking have

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known and inherent risks and it may be the cause of these diseases. That is what I have testified to and that is what I believe.

Q. Well, don't you recognize that the position you've given me which you say is your personal point of view is in fact the industry position?

A. It is and may be, but I'm giving you my point of view. That's what I am under oath to testify to.

Q. Isn't it a fact, Mr. Schindler, that the reason Bennett Lebow's so-called admission became a front page story around the country is because up until that time no CEO or owner of any tobacco company has ever admitted publicly that cigarette smoking causes cancer?

A. Perhaps you're right.

Q. And certainly you're not telling us or are you that it is a coincidence that the CEOs of Reynolds and Philip Morris and brown and Williamson and Lorillard all take essentially the same position that you've expressed here today?

A. Well, I'm testifying to what I believe.

Q. And you're testifying to what you believe as you told us earlier based on discussions that

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you've had with employees of your company in the research and science divisions; correct?

A. It's based on what I believe, it's based on talking to - having discussions with scientists in research and development and my own belief system. It's what I believe.

Q. Who's Jacob Sullum?

A. I don't know who Jacob Sullum is.

Q. You mean in all those hours of preparation no one asked you a question about Jacob Sullum, S-U-L-L-U-M?

MR. WEBER: I'm going to object to the form of the question.

You can answer.

A. I do not recall who Jacob Sullum is.

Q. Do you recall an article published in something called Forbes Media Critic?

Does that ring a bell?

A. No, not that I can think of.

Q. When a governmental entity, let's say, the Los Angeles City Council or the New York City City Council is discussing proposals related to banning cigarette smoking in various facilities, buildings and otherwise, what is - has the position of your company been with respect to those bans?

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A. Our position would be to try and reach accommodation in a facility with both smokers and nonsmokers.

Q. And trying to reach accommodation proves impossible, is it fair to say that you fight the bans, you do everything within your power legally to oppose smoking being entirely banned in a given building or facility?

A. Our position is to try and influence the policy and decision makers so that both smokers and nonsmokers could be accommodated in whatever the building is or public entity that's involved.

Q. When you walked into this building did you - this building where your deposition is being taken today at 599 Lexington in Manhattan, did you notice whether it's a nonsmoking building?

A. Well, yes. I've seen no smoking signs around. Yes.

Q. What do you think the agenda of this building is?

A. Nonsmoking.

Q. Yeah.

But why?

Why does this building in your judgment have a nonsmoking policy?

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1 Wouldn't you assume it's because they've
2 been convinced that secondhand smoke is hazardous to
3 the health of people?

4 MR. WEBER: Let me object to all these
5 assumptions you're building in. Object to the
6 form of the question.

7 If you can answer, go ahead.

8 A. I don't know if it's that, if it's
9 because of all the publicity and lawsuits surrounding
10 it, they're trying to protect themselves from
11 lawsuits. I don't know if it's because people in the
12 building don't want smoking. You know, there's a
13 variety of reasons.

14 Q. Is there anything that causes cancer?

15 A. Is there --

16 Q. Anything that causes cancer?

17 Your position is cigarette smoking

18 doesn't, it may or it may not.

19 But is there anything that you accept
20 yes, exposure to this particular environmental agent I
21 accept causes cancer?

22 A. I am not a medical expert. For me to sit
23 here and recite those things that --

24 Q. Just one. I'm not asking you to recite.

25 Just one.

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1 Is there any one thing that you --
2 MR. WEBER: Were you done with your
3 answer when he interrupted?

4 A. Uh-huh.

5 Q. Is there any one thing that you would
6 concede causes cancer?

7 A. I'm not a medical expert to sit here and
8 identify what causes a cancer.

9 Q. Is Camel cigarettes today essentially the
10 same as it was ten years ago?

11 A. I would - in terms of ten years ago, I
12 would say essentially the same.

13 You're talking about tar and so forth?

14 Q. Taste from the standpoint --

15 A. It's essentially the same, yes.

16 Q. Okay. Is that true of all your brands
17 that have been around for at least ten years?

18 A. Yes, I would say that's essentially the
19 case.

20 Q. What is tar?

21 A. When you burn the product, it's the dark
22 substance that, you know, a variety of chemicals.
23 It's a function of the combustion of the cigarette.
24 It's called tar.

25 Q. The title of this is Can We Have An Open
KLEIN, BURY & ASSOCIATES, INC.

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1 Debate About Smoking. It's obviously an R.J. Reynolds
2 Tobacco Company ad.

3 Have you seen that before?

4 MR. MOSS: Is that marked with a number
5 or something?

6 A. Did you want it back?

7 MR. ROSENBLATT: Why don't you mark this.
8 Plaintiff's Exhibit Two.

9 MR. WEBER: Do we have a - is that a
10 clean one?

11 MR. ROSENBLATT: Yes.

12 MR. WEBER: Andy, hang on just a second.
13 Let Stanley take that back and see if he can
14 put in a better copy for the record.

15 MR. ROSENBLATT: It's the same. This is
16 clean. Why don't you mark that.

17 (Whereupon, the above referred to document
18 was marked as Plaintiff's Exhibit No. Two for
19 Identification.)

20 Q. (By Mr. Rosenblatt) This is an ad,

21 Mr. Schindler --

22 A. Can I finish?

23 MR. WEBER: Wait just a minute. He got
24 interrupted in his reading there. Let him
25 finish up.

KLEIN, BURY & ASSOCIATES, INC.

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1 A. Okay.

2 Q. You've seen this ad before?

3 A. I've seen it a couple times before, yes.

4 Q. Okay. Is there anything in this ad you
5 disagree with?

6 A. Could you be more specific?

7 Q. No. It's one page. You've read it.

8 My question is, is there anything in that
9 ad you disagree with?

10 A. It seems to be rather general to me. It
11 says that there was controversy and we'll be saying
12 some things in the future about it.

13 And on that basis I don't know what to
14 disagree with.

15 It's kind of vague.

16 Q. Well, do you know when this ad was
17 published?

18 A. I believe from - well, yes. It's up here
19 at the top. It says 1984.

20 Q. Now, starting in the third paragraph
21 follow along with me, quote, over the years you've
22 heard so many negative reports about smoking and
23 health and so little to challenge these reports that
24 you may assume the case against smoking is closed, but
25 this is far from the truth. Studies which conclude
KLEIN, BURY & ASSOCIATES, INC.

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1 that smoking causes disease have regularly ignored
2 significant evidence to the contrary, end quote.

3 Do you agree with what I've just read?

4 Is that still the position of R.J.

5 Reynolds Tobacco Company?

6 A. Well, my position is, that cigarette
7 smoking is a health risk and may cause these certain
8 diseases that we've been discussing throughout this
9 deposition.

10 I don't know if that agrees or disagrees
11 with what's stated here.

12 That's my position.

13 Q. So if this is a 1984 ad, which it is, now
14 we're in 1997 --

15 A. Right.

16 Q. -- the situation, in spite of all the
17 millions of dollars being spent on research, from
18 Reynolds's point of view is still precisely the same?

19 MR. WEBER: Object to the form of the
20 question.

21 Go ahead and answer.

22 Q. It was a risk factor in '84, it's a risk
23 factor today, correct?

24 A. I believe it's a risk factor.

25 MR. ROSENBLATT: Okay. I'll try to find
KLEIN, BURY & ASSOCIATES, INC.

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1 a clean copy of this before I have it marked or
2 we'll replace it later.

3 MR. WEBER: Do you want take two minutes
4 and get some clean copies.

5 MR. ROSENBLATT: No. I want to keep
6 moving.

7 MR. WEBER: Because I'd really prefer to
8 get something that's not marked up with your --

9 MR. ROSENBLATT: There may be certain ads
10 I don't have a clean copy. Here I do, though.

11 (Whereupon, the above referred to
12 document was marked as Plaintiff's Exhibit No.
13 Three for Identification.)

14 Q. (By Mr. Rosenblatt) Now I'm going to
15 show you an ad, Mr. Schindler, with some three
16 policeman, a police car - two police cars and one of
17 the police officers is pointing a gun at somebody's
18 house, and the Reynolds headline is, Come Out Slowly,
19 Sir, With Your Cigarette Above Your Head.

20 My question to you is, was Reynolds
21 engaging in some hyperbole with that ad?

22 A. May I read the ad?

23 Q. Sure.

24 You've read it now?

25 A. Yes.

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Q. Now, can you answer my question as to whether or not when this picture is shown Come Out Slowly, Sir, With Your Cigarette Above Your Head, is it not true that Reynolds was engaging in some hyperbole, some exaggeration in order to make a point with this ad?

A. I don't view this as hyperbole or exaggeration.

I think all the things that are described in here, extremely high levels of taxation, the total banning of smoking, the correlations or attempting to correlate cigarette smoking with heroin, cocaine, to me broadly does represent the attempt or inclination towards a backdoor prohibition, sort of taking a product that in our society that has been legal, social policy said for all these years legitimate to sell and suddenly portraying it in all the way that it has been portrayed, to me it's not hyperbole to suggest that the incentive of people that are opposed to the existence of this product in our society are directed toward some form of criminalization of the selling of the product.

So I don't view it as hyperbole.

Q. In the recorded history of mankind can you cite me to one instance where three police

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officers went to somebody's house, a cop pulled a gun, with his gun drawn pointed toward the house and said come out slowly, sir, with your cigarette above your head?

Isn't that hyperbole or is that meant to portray realism?

A. I think there are two things in this ad, I think one is the visualization and the statement at the top and the other is the content of the ad.

Q. I'm limiting my question to the visualization and to what I asked you in the question.

If you don't concede it's hyperbole, fine, but please answer my question.

A. I'm responding to both what is in the picture and the statement and what is in the ad.

Q. Mr. Schindler --

A. And in the total context I don't view it as hyperbole.

Q. Mr. Schindler, you're deliberately misunderstanding my question.

I want you to limit yourself to the picture and the headline. I want you to limit - if you're capable of doing that, it calls for making a distinction. For the purpose of this question leave out the text. Focus in on the photograph and the

KLEIN, BURY & ASSOCIATES, INC.

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headline.

Those taken alone, the photograph and the headline, would you not agree that Reynolds is engaging in hyperbole?

A. I don't --

MR. WEBER: Wait just a minute. We're not going to engage in any name calling here, Stanley. You may not like --

MR. ROSENBLATT: I didn't call any name.

MR. WEBER: Wait just a moment. You let me finish my statement. I don't interrupt you.

My statement is this; you just said that a witness under oath was deliberately misunderstanding a question. That's a very serious thing to say. It's not one I'm sure you meant.

MR. ROSENBLATT: Totally true.

I did mean it. I did mean it.

MR. WEBER: You let me know when you're done so I can make my statement?

MR. ROSENBLATT: I'm done. I'm done. Make your statement.

MR. WEBER: Can I talk now without being interrupted?

MR. ROSENBLATT: Sure.

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MR. WEBER: We're not going to have that kind of name calling here. We're not going to have that kind of insult here.

You have a right to ask this man questions. He has a right to give his answers. You may not like his answers. That doesn't give you the right to insult him, period, end of sentence.

MR. ROSENBLATT: He does not have the right to deliberately misunderstand a clear question.

And I assume, Counselor, with all due respect, that was the purpose of the many, many hours.

Now, I am entitled to ask, as you said, question and I said my question limits itself to the picture and the headline, forget the text. And then he will come back and talk about the text.

So that is the reason for my legitimate frustration.

Q. (By Mr. Rosenblatt) And I say again, Mr. Schindler, in terms of this question please just look at the photograph and the headline, and my question simply is, would you not agree that taking KLEIN, BURY & ASSOCIATES, INC.

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the photograph and the headline alone, not the text, that Reynolds is engaging in hyperbole?

MR. WEBER: Let me move to strike the entirety of the preamble to that including the statements in it.

If you want to go ahead and answer the question, go ahead.

A. I don't believe it's hyperbole in the context of the attacks that are continually going on in our society against this product that has been legal and part of our social policy for many, many years to be - as a legitimate product. I don't view it's hyperbole given the attacks that are taking place.

Q. What social policy are you referring to?

A. I would define that our society through the legislative processes have evaluated the risks of cigarettes in terms of health risks and said it's legal to sell this product under conditions prescribed.

And I don't believe that this ad is hyperbole in the context of the attacks that have taken place over recent years.

Q. This is one of the Reynolds accommodation ads; is that correct?

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Where the focus of the ad is let's have dialog, let nonsmokers and smokers try to get along without government intervention and try to work out our problems, that's what I mean when I call it one of Reynolds's accommodation ads.

Do you think that's a fair characterization of this ad?

A. It is one - I believe --

Was this ad in '94 or somewhere in that period?

Q. Yes. This ad appeared in the New York Times August 23, 1994.

A. There were a number of ads that were run during that period that spoke to the various issues related to this smoking in our society, and this is one of those ads.

Q. And my question is, is it one of Reynolds' accommodation ads?

A. Well, I'm not familiar with what you're talking about as accommodation ads.

Q. Do you see the word accommodation in this ad, last paragraph?

A. Yes. Okay. Well, it's in this ad.

Q. Yes.

Isn't it your understanding that

KLEIN, BURY & ASSOCIATES, INC.

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1 accommodation is one of the key words that was used in
2 that ad campaign by Reynolds during 1994?
3 A. Yes.
4 Q. Okay.
5 A. Okay.
6 Q. Now, you would agree that this ad is
7 essentially a political ad, wouldn't you?
8 A. I think it's an ad to get our point of
9 view out to the American public.
10 Q. This is not an ad about smoking and
11 health, is it?
12 It's an ad essentially about get the
13 government off our backs, let's try to work out these
14 problems without government interference or
15 intervention; is that not a fair characterization of
16 this ad?
17 MR. WEBER: Let me object to the form.
18 Go ahead and answer.
19 A. I think it's an ad talking about our view
20 that the - the company's view that this issue has
21 gotten to this point and it needs to be represented by
22 us as our point of view and needs to be discussed in
23 our society, the whole notion of coexistence, and do
24 you really need the government to tell you you can't
25 smoke in public parks and places like that.
KLEIN, BURY & ASSOCIATES, INC.

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1 Q. Now --
2 MR. ROSENBLATT: Was that marked? Please
3 mark the - that ad entitled Come Out Slowly,
4 Sir, With Your Cigarette Above Your Head,
5 that's going to be Number Three.
6 A. Do you have another copy of this?
7 There's words sort of maybe missing on the end.
8 Q. Mine - my copy is a poor copy, too.
9 I don't think it's important,
10 Mr. Schindler, that you read every word of that unless
11 you want to because my question is not going to be so
12 detailed.
13 You've seen that ad before --
14 A. Wait.
15 Q. You have not?
16 A. I don't remember this one.
17 Q. Okay. Then --
18 A. When was this done?
19 Q. Also - this one was October 25, '94.
20 Appeared in the New York Times on that date.
21 A. I don't remember this one.
22 Q. Okay. But glancing at it, would you
23 agree that this ad is in the same general framework
24 and category of the previous ad which just discussed,
25 Plaintiff's Exhibit Three?
KLEIN, BURY & ASSOCIATES, INC.

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1 MR. WEBER: Let me make an objection
2 before you answer, Mr. Schindler.
3 As Mr. Schindler noted when he was
4 reading it, Stanley, there's words cut off all
5 down the left column.
6 I glanced at that briefly. I can't make
7 out what it means.
8 Also, it hasn't been marked as an
9 exhibit. You may want to mark it.
10 I'll object to any questions being asked
11 on an imperfect copy that doesn't include all
12 the text.
13 I don't know how anyone could answer off
14 that.
15 MR. ROSENBLATT: Please mark that as
16 Plaintiff's Exhibit Four.
17 (Whereupon, the above referred to
18 document was marked as Plaintiff's Exhibit No.
19 Four for Identification.)
20 Q. (By Mr. Rosenblatt) Well, you do see --
21 You do recognize that this is an R.J.
22 Reynolds Tobacco Company ad; correct?
23 A. Yes.
24 Q. Okay. And it's obvious to you from the
25 tone and the words used in the headline that again the
KLEIN, BURY & ASSOCIATES, INC.

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1 thrust of this ad is that we should avoid government
2 interference and intervention and we should try to
3 work out problems between smokers and nonsmokers
4 through accommodation?
5 A. Yes.
6 Q. Okay. Now, even though there are -
7 actually, I don't even think full words are missing in
8 this particular paragraph, a couple of letters, but -
9 this is what I'm talking about. Quote, the time has
10 come to say enough. The time has come to allow adults
11 in this country to make their own decisions of their
12 own free will, without government control and
13 excessive intervention, end quote.
14 Would you agree that that statement I
15 just read was the thrust of the advertising campaign
16 in 1994?
17 A. Of this ad.
18 Q. Okay.
19 MR. ROSENBLATT: Why don't do you mark
20 this as Plaintiff's Exhibit Five.
21 (Whereupon, the above referred to document
22 was marked as Plaintiff's Exhibit No. Five for
23 Identification.)
24 MR. WEBER: Let me see that for a minute
25 before we get started to make sure we've got
KLEIN, BURY & ASSOCIATES, INC.

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1 the whole ad on here.
2 Again, Stanley, it's copied and cut off
3 at the top, so again it appears to be
4 incomplete.
5 MR. ROSENBLATT: But I think in this ad
6 every word and every syllable is in it.
7 MR. WEBER: You guys got the words this
8 time.
9 Q. (By Mr. Rosenblatt) Read me the
10 headline.
11 A. Everywhere We Go Americans Are Telling Us
12 They Want The Government Off Their Backs.
13 Q. You're familiar with this ad?
14 A. Yes.
15 Q. What was your position in September of
16 '94 with R.J. Reynolds?
17 A. President.
18 Q. You were president of the company?
19 A. Chief operating officer.
20 Q. I assume that the company didn't spend
21 the money for a full page ad in the New York Times and
22 many other newspapers without your knowing about it,
23 so you obviously approved this?
24 A. The approval authority in this was Jim
25 Johnston, who I reported to at that point.
KLEIN, BURY & ASSOCIATES, INC.

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1 I remember the ads. It's been several
2 years now.
3 Q. Okay. And again, this is Plaintiff's
4 Exhibit Five. Would you agree that generally speaking
5 when you look at the whole ad this is - the thrust of
6 the ad is, get the government off our backs?
7 MR. WEBER: Let me object to the - to any
8 question that says looking at the whole ad
9 because you only provided him a portion of the
10 ad. The top of the ad is cut off on your
11 Xeroxing.
12 Q. Looking at what is there, you would agree
13 the thrust of the ad is get the government off our
14 backs?
15 A. Yes.
16 Q. Okay.
17 A. So people can reach accommodation on many
18 of these issues.
19 MR. ROSENBLATT: Plaintiff's Exhibit Six.
20 (Whereupon, the above referred to
21 document was marked as Plaintiff's Exhibit No.
22 Six for Identification.)
23 Q. (By Mr. Rosenblatt) You've seen this ad
24 before?
25 A. Yes.
KLEIN, BURY & ASSOCIATES, INC.

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Q. The title of it is, The Smell Of Cigarette Smoke Annoys Me, But Not Nearly As Much As The Government Telling Me What To Do.

A. Yes.

Q. This ad relates to secondhand smoke; is that correct?

Take your time reading it, if you need to.

A. I'd like to read it.

Yes. It seems to be about secondhand smoke and accommodation.

Q. Okay. So from that standpoint the Reynolds' ads in 1994, whether they related to active smoking or secondhand smoke, the thrust was essentially the same; get the government off our backs and let's try to work out these problems between smokers and nonsmokers on a voluntary, common sense accommodation basis?

A. The thrust of these ads is accommodation, people can work out their differences.

MR. ROSENBLATT: This would be Plaintiff's Exhibit Seven.

(Whereupon, the above referred to document was marked as Plaintiff's Exhibit No. Seven for Identification.)

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Q. (By Mr. Rosenblatt) Mr. Schindler, again, looking at this ad, which appeared in the Wall Street Journal and many other publications in June of 1994, the thrust of this ad, Plaintiff's Exhibit Seven, is similar to the previous ads, in the sense of the government is going to far, let's try to work this out through accommodation?

MR. WEBER: Let me object to that question on a couple grounds. One is the form. Second, because Mr. Rosenblatt testified at the beginning of it regarding where it appeared, and Mr. Rosenblatt's job is to ask questions, not to testify. And thirdly, to the vagueness.

Q. Do you agree, Mr. Schindler, that this ad is part of the campaign that we've been talking about that Reynolds published in 1994 and you've seen these ads before?

A. This ad - yes. It seems to be directed at proposed OSHA regulations, as I recall, that the - expressing the opinion that those regulations were going too far and that people could develop their own approaches among themselves as to how to accommodate smoking rather than having these types of proposed regulations being implemented.

Q. Okay.

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A. This one specifically speaks to trucks and possibly to your own home.

Q. Is it fair to say that the purpose of these ads was to persuade public opinion to adopt the Reynolds' view, which was, there's too much government interference and we should work these problems out through accommodation?

A. I think the point of view that's being expressed in these ads is, that people can work out among themselves how to accommodate smoking in our society in many of the situations illustrated in these ads.

MR. ROSENBLATT: Plaintiff's Exhibit Eight.

(Whereupon, the above referred to document was marked as Plaintiff's Exhibit No. Eight for Identification.)

Q. The title of which is Secondhand Smoke. How Much Are Nonsmokers Exposed To.

You've seen this ad before?

A. Yes, a long time ago.

Q. Yes.

And you would agree that the purpose of this ad is to persuade readers that the dangers of secondhand smoke have been greatly exaggerated?

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MR. WEBER: Could you give him a second to read it. He didn't have a chance to read it.

A. Can I read the ad?

MR. WEBER: Stanley, we're just about at an hour. Maybe if you finish this series.

MR. ROSENBLATT: Fine. I'll just do one more and we'll make a break.

A. Yes. Go ahead.

MR. ROSENBLATT: Read him my question.

(Thereupon, the requested portion of the record was read back as above recorded.)

A. No, I don't agree that that's necessarily how you interpret this ad.

Q. (By Mr. Rosenblatt) What's your interpretation of the ad?

A. It's just - the ad is essentially about accommodation. The ad's just simply trying to, I suppose, put in some layman terms what may on average be exposure in different situations. It's not clear to me that it's necessarily talking about risk and that type of thing.

In fact, the ad says cigarette equivalent calculations are not necessarily relevant to the assessment of the potential risk from secondhand

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smoke.

Q. But you would agree that it was the position of R.J. Reynolds Tobacco Company in 1994 and it is the position of R.J. Reynolds Tobacco Company today with respect to secondhand smoke that secondhand smoke does not cause disease and there's nothing to worry about?

A. As I testified earlier before we had our lunch break, that I believe the epidemiology does not point in the direction of secondhand smoke being a risk factor for these diseases.

Q. That's your position today and that was your position in '94?

A. That's the position I've testified here to today, yes.

Q. I'm handing you another ad, another R.J. Reynolds Tobacco Company ad, the title of this is Secondhand Smoke, The Myth And The Reality. Number Nine.

(Whereupon, the above referred to document was marked as Plaintiff's Exhibit No. Nine for Identification.)

A. This ad is from what time period?

MR. WEBER: Just for the record, Andy, he can't tell you what time period it's from. He

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can't testify. So keep in mind he'll ask you questions. But when it is, if you know, you know. If you don't, you don't.

Q. But I do know when this ad appeared. The Wall Street Journal in May of '84. And the ad we're referring to the title of which is Secondhand Smoke, The Myth And The Reality.

MR. MOSS: What was the date you said?

MR. ROSENBLATT: May 17, 1984, the Wall Street Journal.

Q. (By Mr. Rosenblatt) You would agree, would you not, Mr. Schindler, that the myth referred to in the headline is the myth that secondhand smoke causes disease, Reynolds in '84 considered that to be a myth and Reynolds in '97 considered that to be a myth; correct?

A. I believe that there's not scientific evidence that shows that secondhand smoke causes these disease.

Q. Meaning it's a myth; right?

I mean, that's your word. I didn't pick that word.

A. It's a word that's in this ad.

Q. It's a Reynolds ad, that says it's a myth.

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 1 Q. You thought it was a myth in '84, you
 2 think it's a myth in '97; correct?
 3 A. I didn't put the words in this ad in
 4 1984.
 5 I'm telling you that I don't believe
 6 there's scientific evidence.
 7 Q. You don't like the word myth?
 8 A. It's a word. I mean, I'm not
 9 quantitatively evaluating it.
 10 Q. You're not disowning it, are you?
 11 A. The word is in the ad.
 12 Q. And you accept it?
 13 It's a Reynolds ad and it contains the
 14 word myth?
 15 A. It does.
 16 Q. And you're not repudiating this ad, are
 17 you?
 18 A. I believe that there is not scientific
 19 evidence that points to secondhand smoke as a risk
 20 factor for the diseases that we've been talking about
 21 here.
 22 Q. Who is Diane Burrows?
 23 A. Diane Burrows was a lady that worked in
 24 our marketing research group a number of years ago.
 25 She's not with the company any more. I'm not exactly
 KLEIN, BURY & ASSOCIATES, INC.

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 1 sure when Diane left, it's three or four years ago.
 2 Q. What was her title?
 3 A. I don't remember Diane's title. I just
 4 know she was a manager in our marketing research
 5 group.
 6 Q. In the same ad that we're talking about,
 7 Plaintiff's Exhibit Nine, I'm quoting the Reynolds ad,
 8 but in fact there's little evidence and certainly
 9 nothing which proves scientifically that cigarette
 10 smoke causes disease in nonsmokers, end quote.
 11 My question to you, sir, is, that was the
 12 position of Reynolds in 1984, that's the position of
 13 Reynolds in 1997; correct?
 14 A. Yes.
 15 MR. ROSENBLATT: Okay. Let's take a
 16 break.
 17 (Whereupon, a short break was taken.)
 18 (Whereupon, the above referred to
 19 document was marked as Plaintiff's Exhibit No.
 20 10 for Identification.)
 21 Q. (By Mr. Rosenblatt) Mr. Schindler, I'm
 22 going to hand you at this time a rather thick document
 23 called Strategic Research Report published by the
 24 KLEIN, BURY & ASSOCIATES, INC.
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 1 marketing development department R.J. Reynolds Tobacco
 2 Company, Winston-Salem, North Carolina. It's been
 3 marked as Plaintiff's Exhibit 10. I want to ask you
 4 some questions about that document.
 5 MR. WEBER: Do you have a copy for me,
 6 Stanley?
 7 MS. ROSENBLATT: These are the only two
 8 we've got.
 9 MR. WEBER: I've got to object.
 10 MS. ROSENBLATT: You want to to just run
 11 off a copy of that?
 12 MR. WEBER: No. Because I want to get
 13 going. I may want to when we get into this.
 14 Let's just go.
 15 Q. And it's from Diane S. Burrows, who we
 16 discussed before the break.
 17 A. Uh-huh.
 18 Q. Okay. And the date of this is February
 19 29, 1984.
 20 Go to page three.
 21 Do you see where it says abstract in the
 22 middle?
 23 A. Yes.
 24 Q. The first sentence is quote, younger
 25 adult smokers are shown to be critical to long-term
 KLEIN, BURY & ASSOCIATES, INC.

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 1 brand company --
 2 MR. WEBER: Stanley, I'm confused. He
 3 gist turned one page to what you said was page
 4 three. Do we have --
 5 MR. ROSENBLATT: For some strange reason
 6 the first page is page two.
 7 MR. WEBER: So we're not missing a page,
 8 as far as you know?
 9 MR. ROSENBLATT: Correct.
 10 MR. WEBER: Go ahead. Start your
 11 question again. I was confused.
 12 Q. (By Mr. Rosenblatt) On page three this
 13 statement appears, quote, younger adult smokers are
 14 shown to be critical to long-term brand company growth
 15 in the past, present and future, end quote.
 16 Is that a true statement?
 17 A. That's the statement that's in this -
 18 it's in this report.
 19 Q. Do you agree --
 20 I'm sorry.
 21 A. That's the judgment that the researcher
 22 here, Diane, who authored this, came to that
 23 conclusion.
 24 Q. Do you agree with it?
 25 A. It may be true.
 KLEIN, BURY & ASSOCIATES, INC.

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 1 Q. Go to page five. In the middle of the
 2 page there's a section the title of which is, the
 3 importance of younger adult smokers. Quote, younger
 4 adult smokers have been the critical factor in the
 5 growth and decline of every major brand and company
 6 over the last 50 years. They will continue to be just
 7 as important to brands, companies in the future for
 8 two simple reasons, the renewal of the market stems
 9 almost entirely from 18-year-old smokers. No more
 10 than five percent of smokers start after age 24. The
 11 brand loyalty of 18-year-old smokers far outweighs any
 12 tendency to switch with age.
 13 Have I read that correctly?
 14 A. Yes.
 15 Q. Do you agree with those statements?
 16 A. I don't know if I agree with that or not.
 17 I'd have to - this is a rather lengthy report. I'd
 18 have to have some time with Diane to understand how
 19 she drew those conclusions.
 20 I mean, I know in the history of the
 21 industry there have been switching of smokers
 22 substantially older than 18. In recent times there's
 23 been switching during the late '80s, early '90's,
 24 relative to savings brands developing and that type of
 25 thing. So it's hard for me just looking at these two
 KLEIN, BURY & ASSOCIATES, INC.

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 1 bullet points to agree with this judgment that's laid
 2 out here.
 3 Q. Look at the top of page seven. Quote,
 4 younger adult smokers are critical to RJR's long-term
 5 performance and profitability. Therefore, RJR should
 6 make a substantial long-term commitment of manpower
 7 and money dedicated to younger adult smoker programs,
 8 end quote.
 9 Do you agree with that and did RJR give
 10 such a commitment?
 11 A. Again, this is a judgment that Diane has
 12 stated in this document.
 13 Without me having access to the total
 14 research or talking with Diane to understand her
 15 judgments, it's hard for me to say I agree with that
 16 or disagree with that or partially agree with that.
 17 Again, there's been switching in the
 18 industry over time that is not related to younger
 19 adult share of market and there's share growth as a
 20 function of your strength and younger adult market.
 21 But this - it's hard for me to totally
 22 agree or disagree without access to the full research
 23 and talking to Diane.
 24 Q. Well, to your knowledge, after this
 25 strategic research report came out in 1984, did anyone
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ever higher up in the company repudiate it or take issue with it?

A. - I don't think it's - I don't know.

I mean, there's a sense in the business that if you have a share, a stronger share among young adult smokers, that your potential for growth longer term is higher than if you don't. I mean, that's one of the models that is viewed as the industry.

The other is, if you can create significant product change, that you can engage switching otherwise, which has also been part of the trend of the industry.

There's really two points of view, two different points of view as to how you can potentially grow your market share over time.

Q. Look at page 11, please, under volume.

A. I don't have - page 11?

Q. Yes.

A. I'm sorry.

Q. Quote, younger adult smokers are the only source of replacement smokers. Repeated government studies, Appendix B, have shown that less than one-third of smokers start after age 18, only five percent of smokers start after age 24.

And a little further down in the next
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paragraph it says, quote, if younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle.

Do you agree with that?

A. No.

Q. What don't you agree with?

A. Well, this is a concept or theory that Diane Burrows in 1984 developed and, you know, I don't know that that's true, the notion here that - that's being proposed in this document.

MR. WEBER: While they're talking, can I look at those pages you've been through?

Thank you.

Q. Page 42. On this page 42 is at the bottom rather than at the top, as some of the earlier pages were.

Okay. On page 42 Opportunity Analysis, black, Hispanic, younger adult smokers and it - obviously this page talks about blacks and Hispanics and has various statistics and percentages.

So you would agree that at various times in terms of looking at your customer pool that R.J. Reynolds would sometimes look at different segments of the population such as black and Hispanic to figure
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out what their preferences were in terms of cigarettes and how to appeal to a given market?

A. Yes. That's what's in this report.

Q. Okay. And on page 43 it's obvious that Hispanics were subdivided into Mexican, Puerto Rican, Cuban and other; correct?

A. Yes --

MR. WEBER: Give him a chance to look at it.

A. It's a lot of stuff here, Mr. Rosenblatt.

Q. I'm sorry. Go ahead.

A. Yes. Okay. What was your question?

Q. And obviously --

MR. WEBER: He didn't answer. He said yes, okay.

A. What's the question?

Q. My question was simply to confirm that in terms of this document Hispanics are subdivided into Mexican, Puerto Rican, Cuban and other?

A. Yes.

Q. And also looking at the bottom of page 43 it tries to project the US population in Mexican, Puerto Rican, Cuban and other Hispanics between 1980 projected to the year 2000?

A. Yes. It's apparently taken out of

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something - source of center for continuing study of the California economy.

Q. Now, on page 44 under key points, the number one key point it says blacks slash Hispanics will comprise 20 percent of all younger adult smokers by 1990.

And my question to you is, did that turn out to be essentially correct, that projection?

A. I don't know.

Q. Okay.

Q. Now, the last key point says as follows: Philip Morris has placed much heavier emphasis on ethnic spending on recent years and evolved ongoing Hispanic campaigns for Marlboro and Benson and Hedges.

Do you accept that to be true, that Philip Morris did that?

A. That's what this report says. I don't know if that's true. This is in 1984.

Q. Okay. Did Reynolds attempt to emulate that Philip Morris behavior in the sense of giving greater and heavier emphasis to ethnic spending?

MR. WEBER: Let me object to the form.

He just said he doesn't know if he did that.

MR. ROSENBLATT: I thought he said he didn't know if Philip Morris did.

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MR. WEBER: Now you're asking him if he copied what Philip Morris did.

MR. ROSENBLATT: I don't see any inconsistency.

MR. WEBER: You can ask a better question.

Q. (By Mr. Rosenblatt) Did Reynolds place a heavier emphasis on ethnic spending in the last ten years or so?

A. In the last ten years?

Q. Yes.

A. We don't have any - I mean, I can --

Q. Or the last 20 years?

A. In the last 20 years?

There's not a heavy emphasis on ethnic spending in the marketplace today from Reynolds. Over a span of 20 years, I don't know if there are periods in there where there were or were not.

This report was in 1984. I was a plant manager in 1984. I'm not familiar with the content and marketing budgets over a 20 year horizon. I'm familiar with them today.

Q. Yes.

But certainly --

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A. You know, I can't answer the question because of an absence of knowledge relative to a 20 year time span.

Q. Okay. But is it fair to say that upon becoming president and CEO that you made it your business not to necessarily read every word but certainly to familiarize yourself with the background and history of the company?

A. I didn't go back to 1984 and read any research reports since I've been in this job.

Q. Page 49, the title of which is Moving Up In The World, a little past the middle of the page beginning with the words one option successfully used.

Are you with me?

A. Yes.

Q. Quote, one option successfully used by entrepreneurial minorities in the past is to seek fame by exercising special talents in the public eye. Women achieved visible success by the stage or screen or by marriage, blacks moved up through sports and music. Jews became famous on the comedy circuits, poor boys from Liverpool or Mississippi made it with rock and roll, end quote.

Where is that going?

A. You got me.

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1 Q. If you know?
 2 A. I have no idea.
 3 Q. Well, you may not know the answer to this
 4 off the top of your head, but is it fair to say that
 5 you could find out by asking the right person employed
 6 by Reynolds what is our most popular brand with
 7 blacks, with Mexicans, with Puerto Ricans, with Jews,
 8 or is that information unavailable?
 9 A. I don't know if I ask that question if I
 10 could get the answer to all those, I really don't
 11 know.
 12 I mean, you went --
 13 Q. I'm sorry.
 14 A. You went down through African Americans,
 15 Mexicans and Jews.
 16 I mean, I am not sure what you would
 17 happen if I asked that question. I've never asked
 18 that question.
 19 Q. Look at Appendix B. I think it's at the
 20 very end. There's only two later pages after Appendix
 21 B.
 22 A. This one?
 23 MS. ROSENBLATT: Yes.
 24 Q. Yes. The title is Younger Adults
 25 Important - Importance As Replacement Smokers.
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1 Current male smokers by starting age. It
 2 says 9.9 percent of male smokers begin at age 12, 13.4
 3 percent begin by age 13, 20.8 percent by age 14.
 4 You have no reason to question the
 5 accuracy of these statistics, do you?
 6 MR. WEBER: Make sure you read through
 7 that so that everybody understands you're using
 8 the terms the same way.
 9 Q. How are you understanding these numbers?
 10 A. This is the source, according to this is
 11 HEW, Health, Education and Welfare Department, the
 12 Federal government back in 1970 and '75 reported an
 13 adult use of tobacco. So that's the source document
 14 for this. So I have no way of questioning the HEW in
 15 1970 to '75.
 16 Q. Yes. But obviously --
 17 I'm sorry. Go ahead?
 18 A. You're asking me if - repeat the
 19 question.
 20 Q. Well, you have no reason to dispute these
 21 statistics and it's obvious to you that your research
 22 department relied on these statistics; correct?
 23 A. They put these statistics in this report.
 24 These statistics, according to this, come from a study
 25 by HEW, apparently in '70 to '75. So I can neither
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1 confirm these or dispute them. They're from a
 2 government study.
 3 Q. And according to these numbers, by age
 4 15, 30.3 percent of male smokers begin, by age 16,
 5 42.9 percent, and by age 17, 53.6 percent. Those -
 6 I've read the numbers correctly?
 7 A. According to this - what appears to be a
 8 government study.
 9 Q. Okay.
 10 MR. ROSENBLATT: Plaintiff's Exhibit 11.
 11 (Whereupon, the above referred to document
 12 was marked as Plaintiff's Exhibit No. 11 for
 13 Identification.)
 14 MR. WEBER: Just for the record, what was
 15 that, Stanley?
 16 THE WITNESS: The last one we looked at.
 17 MR. WEBER: No, no. This cover sheet.
 18 For 10 there are some fax markings and
 19 indications on this document that don't appear
 20 to have been part of the original. So I just
 21 want to make sure the record is clear on that.
 22 MR. ROSENBLATT: Fine.
 23 Q. (By Mr. Rosenblatt) Okay. You've got
 24 Plaintiff's Exhibit 11 in front of you, which is a
 25 letter dated January 10, 1990, and signed by J.P.
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1 McMahon, division manager of RJR sales company;
 2 correct?
 3 That's what you're looking at now?
 4 A. Yes.
 5 MR. WEBER: Do you have a copy of that?
 6 MS. ROSENBLATT: I have a copy from the
 7 Internet.
 8 MR. WEBER: Thank you.
 9 A. Yes.
 10 Q. Did you ever see this letter before?
 11 A. No, I haven't.
 12 MR. WEBER: I'm sorry, Susan. You gave
 13 me the wrong one. He's got a January 10.
 14 Is that what you think he has, Stanley?
 15 MR. ROSENBLATT: Yes.
 16 MR. WEBER: She just gave me a May.
 17 MS. ROSENBLATT: I don't have another
 18 copy.
 19 MR. WEBER: Well, again, I'll object.
 20 As successful as Stanley is, not to bring
 21 copies for us is inexcusable.
 22 Go ahead.
 23 That saves me reaching over to do it,
 24 Stanley. Thank you.
 25 MR. ROSENBLATT: I did it lighter than
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1 you would have done it.
 2 Q. (By Mr. Rosenblatt) Follow along with
 3 me. This letter to sale reps, subject, young adult
 4 market very important. Please read carefully.
 5 Beginning with the second sentence, I
 6 need all of you to study the attached scroll list of
 7 monthly accounts in your assignment that are presently
 8 doing more than 100 CPW for purposes of denoting
 9 stores that are heavily frequented by young adult
 10 shoppers. These stores can be in close proximity to
 11 colleges, high schools or areas where there are a
 12 large number of young adults frequent the store.
 13 The purpose of this exercise is to be
 14 able to identify those stores during 1990 where we
 15 would try to keep premium items in stores at all
 16 times.
 17 And jumping to the last sentence, I am
 18 asking you to return this list highlighting those
 19 stores that you are classifying as young adults, end
 20 quote.
 21 Mr. Schindler, someone reading this
 22 letter would certainly assume based on this letter
 23 that R.J. Reynolds Tobacco Company was targeting the
 24 young market, wouldn't they?
 25 MR. WEBER: Let me object to the form of
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1 the question.
 2 Go ahead.
 3 A. Do you mean underage smokers when you say
 4 youth mark?
 5 Q. Yes.
 6 A. This is a letter from the division
 7 manager that violated company policy. It's my
 8 understanding - which is that we don't sell cigarettes
 9 or market cigarettes to people under the legal age.
 10 It is my understanding that when this
 11 individual did this, the head of sales formally
 12 reprimanded the individual and then a letter was sent
 13 out to the entire sales force to clarify this
 14 situation so that nobody else would violate company
 15 policy.
 16 So this is a mistake that an individual
 17 made relative to company policy. When discovered, the
 18 company policy intervened to reprimand the individual
 19 and to restate it for the entire company.
 20 So I do not believe that this represents
 21 in any way this company targeting underaged smokers in
 22 their marketing and sales practices.
 23 Q. But you would agree this incorrect letter
 24 by an individual does in fact do that?
 25 A. This letter says that this individual
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1 said this. And this individual was reprimanded for
2 putting this out.

3 Q. Was he fired?

4 A. I don't remember if he was fired or not.
5 I believe he left the company and I don't
6 remember the exact circumstance. But he was
7 reprimanded for doing this.

8 Q. Do you have any explanation as to how a
9 division manager of the sales company would not have
10 known what the company policy was on this subject?

11 A. There are 2500 or so people in the field
12 sales organization. This individual was aware of
13 company policy. Obviously violated in this case. He
14 was reprimanded and the remainder of the sales force
15 was reminded of the company policy.

16 So what this individual did was wrong and
17 was in violation of what our company policy is. He
18 was dealt with accordingly. So to me it's an example
19 of company policy working.

20 There's thousands of people in this
21 company, somebody's going to make a mistake. And when
22 discovered, it's the responsibility of management to
23 intervene on that mistake, which is what happened in
24 this case.

25 MR. ROSENBLATT: Plaintiff's Exhibit 12.
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1 (Whereupon, the above referred to
2 document was marked as Plaintiff's Exhibit No.
3 12 for Identification.)

4 MR. WEBER: I guess we can stipulate that
5 you don't have a copy of this for me.

6 Stanley, are you done with that Exhibit
7 11, that subject matter?

8 Would it - if so, would it be of interest
9 to put in the record that document that Susan
10 handed me a moment ago, the May letter, in
11 which Mr. McMahon writes out to the sales force
12 saying he made a mistake.

13 MR. ROSENBLATT: Absolutely. The May 3rd
14 1990 letter, which I call the mea culpa letter.

15 Do you want that marked?

16 MR. WEBER: I'm just asking. It's
17 deposition. I can't force you to mark it.

18 MR. ROSENBLATT: I agree. I'll be happy
19 to mark it. Let's make it 11 B.

20 MR. WEBER: That's fine.

21 MR. ROSENBLATT: The witness is looking
22 at a letter dated January 11, 1990, from Jo F.
23 Spach, S-P-A-C-H, manager public information,
24 public relations department, R. J. Reynolds
25 Tobacco Company to the principal of Willow
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1 Ridge school in Amherst, New York.

2 A. Yes.

3 Q. (By Mr. Rosneblatt) Do you know
4 Ms. Spach?

5 A. Spach.

6 Q. Spach?

7 A. Yes, I knew Jo. She's retired now from
8 the company.

9 Q. Okay. Were you aware of this letter at
10 the time it went out?

11 A. No, I wasn't.

12 Q. As manager of the public information,
13 public relations department back in January of 1990,
14 approximately how many employees would she have had
15 under her?

16 A. I have no idea. I really don't know.

17 Q. Okay. Now, the letter to the principal
18 begins, a number of your fifth grade students have
19 written R.J. Reynolds Tobacco Company commenting that
20 they do not feel our company should allow the use of
21 our brand names on children's toys and candy
22 cigarettes.

23 Now, going down to the last paragraph on
24 page one of this letter Ms. Spach says, despite all
25 the research going on, the simple and unfortunate fact

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1 is that scientists do not know the cause or causes of
2 the chronic disease - diseases reported to be
3 associated with smoking.

4 Is that a true statement?

5 A. As I've testified before, I believe that
6 cigarette smoking is - may cause these diseases, but
7 it hasn't been proven in the pure scientific sense.

8 Q. Yeah, but this letter doesn't say Andrew
9 Schindler says that. This letter says scientists do
10 not know the cause or causes of the chronic diseases
11 reported to be associated with smoking.

12 And I'm asking you, sir, whether in
13 January, 1990, you believed that scientists did not
14 know the cause or causes of the chronic diseases
15 reported to be associated with smoking?

16 A. I hate to do this, Mr. Rosenblatt, but
17 could you repeat the question again?

18 Q. Okay. I basically want to know if you
19 consider this to be a true statement, the statement
20 we've just gone over and specifically, that scientists
21 in January of 1990 did not know the cause or causes of
22 the chronic diseases reported to be associated with
23 smoking?

24 A. You know, I believe in 1990 the majority
25 of scientists would have felt that cigarette smoking
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1 caused these diseases.

2 It is my view that it is a risk and may
3 cause.

4 Q. Okay. So in that sense the statement's
5 inaccurate?

6 A. I'm giving you my point of view.

7 Q. Which is, you recognize that certainly
8 the majority of scientists and medical doctors did
9 consider that there was a cause and effect
10 relationship between smoking and lung cancer, for
11 example?

12 A. The majority.

13 Q. Okay. Now, Mrs. Spach says in this
14 letter to the principal, presuming he's going to pass
15 the letter onto his fifth graders, we believe that the
16 answer to these questions can only be determined
17 through more scientific research.

18 A. Okay.

19 Q. Okay. Now, you agree with that?

20 A. I believe that more scientific research
21 is needed.

22 Q. Now, the Frank Statement that we talked
23 about earlier today came out in 1954, and the Tobacco
24 Industry Research Committee, which later became the
25 Council for Tobacco Research, was established
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1 supposedly to fund a tremendous amount of research.

2 In 1990 Mrs. Spach is saying we still
3 need more scientific research.

4 And is it fair to say that in April,
5 April 14, 1997, as we sit here today, you are saying
6 that we still need more scientific research on --

7 A. Yes. I think that there's more
8 scientific research needed to try to confirm the
9 causality relative to - and the mechanism relative to
10 smoking and its related diseases, that the lab
11 research on animals up to this point has proved
12 inconclusive as it relates to causality and mechanism.

13 The epidemiology points at cigarettes as
14 a risk factor that may cause these diseases, but lab
15 studies have been inconclusive in that regard and
16 therefore, I think more research is needed. And we
17 continue to fund that research or a good bit of it
18 through CTR.

19 Q. Okay.

20 A. Basic research.

21 Q. It's been 43 years since the Frank
22 Statement.

23 Are people going to be sitting around 43
24 years from today on behalf of the tobacco companies
25 saying that hey, still researching this, still need
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1 some more research, and in the mean time people are
2 smoking and the product is being sold and we still
3 need more research, do you think that will be the
4 position of Reynolds 43 years from today?

5 A. I think it's up to medical science and
6 research to determine whether or not it can be shown
7 what the mechanism is related to these diseases and
8 smoking.

9 Q. Precisely my point, Mr. Schindler.
10 The medical and scientific communities do
11 not believe that more research is needed.

12 A. Well, I don't know that that's true.

13 Q. Because you just said the majority of the
14 scientific and research and medical communities accept
15 the fact that cigarette smoking causes lung cancer and
16 other diseases. They don't think any more research is
17 needed.

18 A. I believe the medical community continues
19 to do research so they must believe it's needed or
20 they wouldn't do the research.

21 Q. What is a trade association?

22 A. A trade association would typically be
23 people engaged in the same business coming together to
24 - as an association to represent the interests of the
25 particular business or industry group that they're in.

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1 Q. Is the Tobacco Institute a trade
2 association?

3 A. Yes.

4 Q. Is the Council for Tobacco Research a
5 trade association?

6 A. No.

7 Q. Are you aware that the Council for
8 Tobacco Research characterizes itself as a trade
9 association when it files its Federal income tax
10 returns?

11 MR. WEBER: Let me object to that because
12 there have been a lot of lawyers in this
13 litigation that have made that statement and I
14 really don't think you're one of the ones who's
15 going to make that statement without having
16 some proof. I think you're somebody who's
17 shown, so far at least, some attention to the
18 documentary record.

19 So if you can show us that you that says
20 trade association and ask him, I'd appreciate
21 it.

22 Or ask him first of all if he knows what
23 they've done and then if you want to show trade
24 association, show him the piece of paper, if
25 you would, please.

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1 MR. ROSENBLATT: Exhibit 13.
2 (Whereupon, the above referred to document
3 was marked as Plaintiff's Exhibit No. 13 for
4 Identification.)

5 MR. WEBER: Is that your only one?

6 Why don't you show him - maybe he can
7 find out what it is he's referring to there.

8 Q. (By Mr. Rosenblatt) Well, looking at
9 Plaintiff's Exhibit 13, the Council for Tobacco
10 Research U.S.A., Inc. characterizes itself as a
11 501(c) 06 entity, and it's my understanding that that
12 makes it a trade association.

13 Do you have any other information on
14 that?

15 MR. WEBER: Well, let me object to that
16 because - and it's an ironic issue that would
17 come up today since we both have our taxes due
18 tomorrow.

19 MR. ROSENBLATT: Not me. I got an
20 extension.

21 MR. WEBER: Okay. Based on that question
22 I would not ask you for tax advice, because
23 501(c) 6 I don't think squares with your
24 understanding.

25 MR. ROSENBLATT: I don't even want to ask
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1 the question. This is a question my wife gave
2 me. She has a tax background. I am lost in
3 this.

4 MR. WEBER: Nobody hits 1000. She's
5 given you some good ones today, Stanley. This
6 was a clinker.

7 MR. ROSENBLATT: Babe Ruth struck out
8 more times than he hit home runs.

9 MR. WEBER: Did he really?

10 MR. ROSENBLATT: Yes. A little known
11 statistics.

12 Q. (By Mr. Rosenblatt) Did you know that?

13 A. Yes.

14 Q. You look like a baseball fan. Okay.

15 Forget it.

16 A. Do you want this back?

17 Q. But I will ask this question,
18 hypothetically speaking, if the Council for Tobacco
19 Research characterizes itself as a trade association
20 on its Federal income tax returns, that would surprise
21 you?

22 Because when I asked you earlier is the
23 Tobacco Institute you a trade association you said
24 yes. When I asked you is the Council for Tobacco
25 research a trade association, I believe you said no.

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1 Correct?

2 A. Right.

3 Q. Okay.

4 A. But you've implied something here that
5 something would surprise me. I mean, I'm --
6 Did you ask me a question or --

7 Q. Yes.

8 My question was, would it not - having
9 given that answer, would it not surprise you if the
10 Council for Tobacco Research characterizes itself as a
11 trade association on its Federal income tax returns?

12 A. Not being attacks lawyer, I could
13 probably tell you nothing would surprise me when it
14 comes to tax law and filling out income tax forms.

15 So I don't know or have any judgment
16 relative to tax law, filing. But to me the Council
17 for Tobacco Research is not what I would view as a
18 trade association in the context of how it operates.

19 How that relates to tax law, that's
20 somebody else's.

21 Q. Does R.J. Reynolds have an employee
22 handbook?

23 A. Yes.

24 Q. How do you communicate, other than
25 through an - the employee handbook, how do you
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1 communicate with your employees?

2 A. We have a video system we call target
3 vision that's in different work areas throughout the
4 company, we have an employee newsletter called
5 Caravan, periodically there might be a letter from
6 different executives to their particular people and
7 their part of the organization or once in awhile a
8 letter from me. A variety of ways. Employee
9 meetings, talking about business issues and so forth.

10 Q. Has R.J. Reynolds Tobacco Company
11 communicated to its employees in any manner whatsoever
12 how to respond to questions commonly asked of the
13 tobacco industry or how to respond to attacks on the
14 tobacco industry, such as, if someone says to you how
15 can you work in this business, you make a product
16 which causes cancer and which kills people; have you
17 suggested to your employees, I don't mean you
18 personally, have you suggested to your employees how
19 to respond to attacks or questions of that kind?

20 A. I don't recall any in terms of - it's not
21 something - you're talking about something that's
22 distributed in some communication form to employees?

23 Q. Or it could be oral?

24 A. I don't recall any such thing in the
25 nature of the question that you're characterizing it.
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1 Q. What clearance if any does an employee of
2 yours need to get in order to participate in a public
3 debate or appear on a radio talk show or a television
4 program?

5 A. Well, they would get authorization if
6 they're representing the company in one of those
7 forums that you're explaining here through public
8 relations and perhaps the legal group, depending on
9 the situation.

10 Q. Does an employee have the freedom of
11 choice to appear on such a public program without
12 getting authorization?

13 A. Well, in our society somebody can choose
14 to do whatever they want.

15 If somebody is representing the company
16 in one of those types of programs, I would expect that
17 they would seek out to get approval from the company
18 to do it.

19 Q. And if they did not, there would be
20 consequences, such as they might lose their job or be
21 reprimanded?

22 A. I don't know that.

23 Q. Well, who would if you don't?

24 A. Well, you're posing a hypothetical
25 question that if somebody was representing the company
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1 without quote authorization they'd be fired, and I
2 don't know that that's true.

3 I'm saying that the policy and practice
4 would be, if you're going to represent the company, it
5 would be good to get authorization to do that.

6 If somebody did it without that
7 authorization, it is not at all clear to me in this
8 hypothetical situation that they would be terminated,
9 which is what you suggested would happen to them.

10 Q. Here's another hypothetical question and
11 please try to accept the facts in the question which
12 are: If it were ever established to your satisfaction
13 through the greatest scientists in the world that
14 cigarette smoking does in fact cause lung cancer,
15 would you quit your job or would you keep selling
16 billions of cigarettes which you are now convinced in
17 my hypothetical kills people?

18 A. I wouldn't quit my job.

19 Q. What would you do?

20 A. Your hypothetical theoretical world that
21 you're creating here in this question, I would ensure
22 with the resources this company had that they would be
23 knowledgeable and aware of this research, and I would
24 assume they already would be, and that it in that
25 process of theoretically coming to that conclusion,
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1 there would be some knowledge about what it is or what
2 it is about cigarette smoking that would cause
3 disease, and then we would be in a position to work to
4 change the product and improve it in that direction,
5 as we have generally worked to improve the product
6 over the last 40, 50 years.

7 Q. Let me carry my hypothetical a little
8 further. You also find out that there's nothing that
9 can be done to the cigarette for it not to cause
10 cancer and death. With all the best intentions in the
11 world, you satisfy yourself that my cigarettes will
12 always cause cancer and death.

13 Hypothetically, if you ever became
14 convinced of that, would you quit your job?

15 MR. WEBER: Object to the form.
16 Go ahead and answer.

17 A. I just think that is a --

18 Q. Ridiculous hypothetical?

19 A. I think it's outrageously hypothetical.

20 My view is, society with the knowledge
21 that you're laying out here, it would seem to me would
22 - and the medical community would come to some
23 understanding about cigarettes and - that hadn't
24 existed before and that we would all work together to
25 figure out how to improve the product. And I believe
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1 that would be the path in your hypothetical world.

2 In your hypothetical world suggesting
3 there's zero opportunity, I don't believe that would
4 be the case. I think that everybody would work to
5 improve the product in the future as we have in the
6 past and as we are today.

7 Q. You have done nothing in the past except
8 reduce tar. And then when I say to you what is the
9 significance of the reduction in tar in terms of
10 peoples health, your answer is you don't know.

11 So what are you telling us R.J. Reynolds
12 has done over the past 40 years to improve their
13 customers' health?

14 A. I think we've responded to the guidance
15 that the public health community gave, pointing to tar
16 as something that should be reduced in cigarettes, we
17 have done that in the company and in the industry and
18 I'm proud of what we have done.

19 I'm proud of what we have done since the
20 early '80s with regard to the development of the
21 product Premier and Eclipse, which we have spent
22 substantial amount of money on, being debated and
23 argued with from anti-smoking establishment through
24 that whole period, that we have sought to improve the
25 product even when not having that cooperative effort
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1 and we would continue to improve the product.

2 And I don't think it's something to say
3 nothing has been accomplished when we have been
4 responding over the years to what public health people
5 said should be done with the product and we have done
6 that. I am proud of what this company has done.

7 Q. Mr. Schindler, what the American Cancer
8 Society and what the Surgeon General says is, get rid
9 of cigarettes?

10 A. Well, then they should petition Congress
11 to ban the product.

12 Q. Now, Premier and Eclipse, are they on the
13 market today?

14 A. Eclipse is.

15 Q. That's a safer cigarette?

16 That's safer than Camels?

17 A. I don't know that it's a safer cigarette.

18 Q. I'm missing something. I'm missing
19 something.

20 You're telling me about all Reynolds has
21 done and you mentioned Premier and Eclipse. And then
22 I ask you is Eclipse any safer than Camels. And if
23 your answer is you don't know, then what constructive
24 good has Eclipse done if it's no safer than Camels or
25 Winston?

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1 A. I don't know if the product is safer.

2 Q. Okay.

3 A. It may have reduced risk, it may not.

4 It has very low tar, it has very low
5 nicotine, virtually no secondhand smoke, and it is a
6 product that we have developed and put into the
7 marketplace and tested.

8 Q. And it's selling like hotcakes, isn't it?

9 A. No, it isn't.

10 Q. It's selling horrible?

11 A. It's in test market in Chattanooga, in
12 Germany, Sweden and Japan.

13 Q. What percentage of the American market
14 does it have?

15 A. It's only in a test market in
16 Chattanooga, Tennessee, in the U.S.

17 Q. Nowhere else?

18 A. Not in the US.

19 Q. So it's never been on the market in US,
20 other than a test market?

21 A. We're in a test market in Chattanooga,
22 Tennessee, test market in Augsburg, Germany, in Sweden
23 and Japan.

24 Q. And Premier was never put on a test
25 market?

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1 A. Yes, it was.
 2 Q. And how did it do?
 3 A. It did terrible.
 4 Q. It bombed?
 5 A. Yes.
 6 Q. And your prediction is Eclipse will bomb?
 7 A. No. I think Eclipse has an opportunity.
 8 Q. Okay. Now, a moment ago you were telling
 9 us how ridiculous my hypothetical was.
 10 Now, you know, don't you, that the World
 11 Health Organization, the National Academy of Sciences,
 12 the US Public Health Service, the National Institute
 13 for Occupational Safety and Health, the Surgeon
 14 General, the United States Environmental Protection
 15 Agency, all have reviewed the scientific evidence and
 16 concluded that not only is active smoking a cause of
 17 lung cancer, but involuntary smoking is a cause of
 18 lung cancer.
 19 Then I ask you a question to assume that
 20 you, Mr. Schindler, become convinced that they're
 21 right, and that to you is an absurd hypothetical.
 22 Why is that an absurd hypothetical?
 23 MR. WEBER: That's a mischaracterization
 24 of what he said, and to the form.
 25 MR. MOSS: We object to the form.
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1 Q. Didn't you say my hypothetical was absurd
 2 because it presupposed that you could be convinced
 3 that your product causes cancer and death and that
 4 nothing could be done to make your product not cause
 5 cancer and death. You thought that was an absurd
 6 hypothetical.
 7 A. You have really, frankly, confused me
 8 with the series of questions you have here.
 9 If you would like to, I would like to go
 10 back to where this all started.
 11 Q. It all started back in 1954, didn't it,
 12 with the Frank Statement to Cigarette Smokers, when
 13 the tobacco industry lied to the American people and
 14 said they were going to do research and get answers,
 15 and 43 years later we're sitting here and you're still
 16 trying to sell the American people the same bill of
 17 goods that more research is needed, cigarette smoking
 18 doesn't cause lung cancer, it's only a risk factor,
 19 like cottage cheese; right?
 20 MR. WEBER: Let me move to strike that.
 21 Save it - object to it. Save it for the jury,
 22 Stanley.
 23 MR. ROSENBLATT: It's called
 24 cross-examination, which is what this is.
 25 MR. WEBER: No. That's called a jury
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1 argument.
 2 MR. ROSENBLATT: Which is what this is.
 3 MR. WEBER: That was called a jury
 4 argument.
 5 MR. ROSENBLATT: That's what I call good
 6 cross-examination..
 7 Q. (By Mr. Rosenblatt) What's your answer
 8 to that?
 9 Answer the question.
 10 A. I'm not sure there was a question.
 11 Q. Oh, there was.
 12 Aren't we telling the same lie today
 13 American people today as we did in '54, that was the
 14 question.
 15 MR. ROSENBLATT: Go ahead and read my
 16 question.
 17 (Whereupon, the requested portion of the
 18 record was read back as above recorded.)
 19 MR. MOSS: Object to the form.
 20 Q. Isn't that true?
 21 A. Like cottage cheese, you're referring to?
 22 Q. The lying I'm referring to. Don't get
 23 sidetracked.
 24 A. I don't believe there's lying.
 25 There's been a lot of money given to the
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1 Council for Tobacco Research administered through an
 2 eminent panel of scientists and medical researchers in
 3 the company, 25 top medical schools, Nobel prize
 4 winners taking that research money, continuing to take
 5 that research money, to do basic research in diseases
 6 that are associated with smoking. I do not see the
 7 lie in that.
 8 Q. And the end result is that 43 years after
 9 the Frank Statement we are - from your standpoint we
 10 are precisely back where we were in 1954 hey, it's a
 11 risk factor, but does it cause lung cancer, it may and
 12 it may not. So that's what 43 years and millions upon
 13 millions of dollars to the Council for Tobacco
 14 Research have accomplished in terms of the bottom line
 15 to the consumer; correct?
 16 MR. WEBER: Let me object to the form of
 17 the question.
 18 You can answer.
 19 A. That research money was given to the
 20 Council for Tobacco Research to provide resources to a
 21 scientific advisory board independent of anything to
 22 do with these businesses to grant - to provide
 23 research grants to eminent scientists and medical
 24 institutions and research institutions around this
 25 country and that has gone on for all these years and
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1 they have been in control, as Nobel prize winners,
 2 there's eminent scientists and the results that they
 3 derive out of that research are published.
 4 So I do not see where that's a lie or a
 5 conspiracy that some of the most eminent medical
 6 researchers and scientists in this country and medical
 7 schools have used this money to research diseases
 8 related to smoking. I do not understand where the lie
 9 or the misleading or the conspiracy is in that.
 10 Q. But all the money spent in the 43 years
 11 leads you to tell us on April 14, 1997, 43 years after
 12 the Frank Statement does Camels cause lung cancer and
 13 your answer is maybe it does and maybe it doesn't;
 14 correct?
 15 A. Yes.
 16 But I don't see the conspiracy of this
 17 institution --
 18 Q. I know you don't.
 19 A. -- putting that money out for people to
 20 do this research.
 21 (Whereupon, a short break was taken.)
 22 Q. (By Mr. Rosenblatt) Mr. Schindler, I'm
 23 going to show you Plaintiff's Exhibit 14, which is
 24 KLEIN, BURY & ASSOCIATES, INC.
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1 entitled Research Planning Memorandum on Some Thought
 2 About New Brands of Cigarettes for the Youth Market.
 3 MR. WEBER: Has that been marked?
 4 MR. ROSENBLATT: I just did it now.
 5 (Whereupon, the above referred to
 6 document was marked as Plaintiff's Exhibit No.
 7 14 for Identification.)
 8 Q. (By Mr. Rosenblatt) Look at the very
 9 first page of that document.
 10 A. All right.
 11 Q. The first sentence in the second
 12 paragraph, quote, realistically if our company is to
 13 survive and prosper over the long-term, we must get
 14 our share of the youth market, end quote.
 15 That's a true statement, isn't it?
 16 It was a true statement really throughout
 17 the history of R.J. Reynolds?
 18 MR. WEBER: Let me object to that
 19 question.
 20 I want to address an issue with you,
 21 Stanley, just briefly.
 22 This is in reference to Exhibit 14, and
 23 I'm not certain, but I would bet this isn't
 24 your fault, but it's a series issue I just want
 25 to make sure we get it addressed.
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The original of this document that's been produced is a document on which the author had marked draft. Indeed in written draft at the top of page one.

Now, there have been some bogus copies of this floating around that some less scrupulous lawyers have whited out the draft statement on the first sheet. This document doesn't exist other than as a draft.

So what I'm saying is, what you've got here at the beginning we know is a bogus copy that somebody gave to you and I just want to make that clear.

You can go ahead and ask questions about it.

But I want - I strongly object to this document being used, because what it is is a - it's hard to figure out what the exact right term is, it's at least a phoned-up document you got from somewhere.

I don't know that you know that. I want to make sure that you do know that, Stanley.

And you can go ahead and ask questions.

A. Who wrote this?

Q. I was going to ask you that.

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Do you know?

A. No.

Q. Or who wrote the draft?

A. Who wrote this draft document? No.

This is in 1973. I wasn't working for the company at that time.

Q. Well, if you look at the last page, Claude E. Teague, Jr., and it's dated February 2, 1973.

Do you know who he was?

A. Yes.

Q. Or is?

A. Yes, I know who Claude Teague is. He worked in research and development.

Q. What was the highest position he achieved at the company?

A. I believe - I'm not totally sure of this, but I believe his highest position was a director in research and development reporting to the head of R & D as an administrative planning person in his last years as a director.

Q. If as your counsel said this is a draft, do you know whether it was ever finalized in publishable form?

A. Well, I don't know what's in here.

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If it was a draft, I would - I mean, I'd have to guess that it wasn't.

I don't - I haven't seen the document.

It's a draft document, as you all have agreed here, from a research and development person who had some thoughts about new brands in 1973.

Q. Well, new brands for the youth market?

A. For the youth market.

Q. But I mean on the - generically speaking, isn't it a true statement to say that for any tobacco company to survive and prosper over the long-term you've got to get your share of the youth market?

A. What do you mean by the youth market?

Q. Eighteen and under.

A. No.

We never have gone after people under the legal age of smoking. It is against company policy. We've never done that and we don't intend to do that. And it's against policy today.

Q. How about 18 to 21?

A. Our share of legal smokers 18 to 21 or 18 to 24 is, you know, something that we would like to improve our share on.

But we don't go after people who are under the legal age of smoking.

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All of our focus groups, for example, today when you get some promotion idea, new ad that you think might be good in the marketplace and you go to focus groups and show it to smokers, we don't bring anybody into those focus groups under the age of 21. We don't even talk to smokers under the age of 21, even though the legal age of purchase is 18. We don't talk to 18 years olds, 19 year olds or 20 years olds. We don't even talk to smokers about any marketing ideas unless they're 21 years old.

Q. When did the Joe Camel campaign begin?

A. It was either in '87 or '88, in that period.

Q. What, if any, was your involvement with that?

A. I wasn't - in '87 I was working in the foods company and '88 for most of that year I was in the foods company.

So the Joe Camel campaign, which is originally a promotional campaign on the 75th anniversary of the brand initiated in the marketplace while I was working in the foods business.

Q. What were you doing in the foods business?

A. I was a director of manufacturing.

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Q. For what product line?

A. A1 Steak Sauce, Grey Poupon Mustard, Ortega, Chung-King, Shredded Wheat, Cream of Wheat, Royal Desserts, Mighty Fine Puddings, and that variety of products.

Q. And the company, the specific name of the company when you were in the foods division?

A. It was Nabisco.

Q. Now, would you agree that the Joe Camel campaign, the ads that one sees on billboards and magazines, the cool Camel characters shooting pool, playing the guitar, the items that are available as freebies or for purchase, aren't they designed for the youth market, 18 and under?

A. Absolutely not.

Q. You think you can sit here with a straight face and say that you think the Camel advertising campaign is directed to what, 40 year olds?

MR. WEBER: Let me object to the form of the question. It's argumentative.

Q. It's cartoon characters?

A. Met Life uses Snoopy to sell insurance. I don't believe they've targeted 15 year olds for life insurance by using Snoopy.

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I don't believe Owens-Illinois with the Pink Panther is trying to get 16-year olds to buy insulation for the homes they're building.

So I can sit here totally confident with a straight face and tell you that there's nothing we're doing with our Camel advertising that targets people under the legal age of smoking.

Q. You would agree, would you not, that the freebies associated with the Camel advertising campaign are freebies, products that would be attractive to the youth market rather than people in their 30s, 40 and 50s?

A. They are for people in their 20s, 30s and 40s. They're not targeted to people under the legal age of smoking.

The Federal Trade Commission reviewed the entire Camel campaign for a period of several years and concluded that contrary to conventional wisdom or peoples' common intuition, it was not targeted at people under age. It didn't cause people to smoke. It wasn't targeted under age. That was the FTC's ruling.

The campaign every year that basically it's been out there is rated among adults as one of the top ten print media campaigns.

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There's never been any attempt whatsoever, it's against the policy to target anything we're doing from the marketing standpoint at people under the age of 18.

I think it would be absolutely stupid with the scrutiny that this industry takes and this company to engage in developing marketing programs that would go at people under the legal age of the purchase of the product.

As I pointed out to you earlier in the development of those things that you suggest are targeted at kids, we don't even talk to smokers under the age of 21 in the development of our marketing programs.

It's pretty difficult to target something at someone that's 15 if you're not talking to anybody in that group, which we don't do.

Q. Well, let's get very practical about this.

How many smokers under the age of 18 have started to smoke Camels since the Joe Camel campaign began in '87 or '88?

A. Are you asking me what percent of underage smokers smoke Camels?

Q. I'm asking you what I asked you.

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A. It is my recollection, based on government statistics that are reported, I think they say somewhere between 10 and 12 or 13 percent of underage smokers smoke Camel. That is what the government reports, is my understanding.

Q. Okay. What was that percentage before the Joe Camel campaign?

A. I'm not sure. I think it might have been in the three percent range or something like that.

Q. How much, if any, has Camel moved up in market share from '87 until today?

MR. WEBER: What market area are you talking about?

A. Total market share.

Q. Yes, total market share?

A. You're not talking about youth market, you're talking about market share?

Q. Correct.

A. Since 1987, as of today, I would say probably in total about six or seven-tenths of a share point, somewhere - it probably moved from four to 4.2 up to a little over five share points today. It's six, seven-tenths. I'm not sure what the share was back in 1987.

It has generally grown two to three share
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points, so we're talking nine years, it's in that - it's somewhere six or seven-tenths to a share point.

Q. So from a purely business standpoint is that money well spent, the money that's been spent?

A. The market share has increased on Camel.

Q. But to a satisfactory level from a business standpoint considering the investment and advertising on Joe Camel?

A. Yes.

Q. Okay. So you're satisfied?

A. Yes.

Q. From a business standpoint?

A. Yes.

Q. Okay. Do you have any reason to dispute the findings that the average six year old recognizes Joe Camel just as quickly as he recognizes Mickey Mouse?

A. I'm not sure that that's true.

I mean, I think you're referring --

Q. And you're not sure it's untrue?

A. Right.

Q. Well, if it's true, do you have any feel for how many of those six year olds when they become 14 are going to start smoking Camels?

A. I don't believe that advertising causes
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anyone to smoke. You know, we've talked about that earlier in this deposition.

The fact that somebody - someone may recognize an ad doesn't mean that they're interested in the product.

In fact, I think some of the research that has been done with regard to recognition of the Camel campaign also shows among underage people where there's a high percentage of recognition, 97 percent of those same people believe that smoking is a bad thing. So it doesn't seem to me that just because you recognize it that it is something that is going to cause you to use that you product, if the very people that recognize it also say smoking is bad for you.

Q. Have you met a lot of smokers in your lifetime who told you they wished they could quit but they can't?

A. I have met smokers that are, you know, people that have smoked that said they would like to quit and I'm sure there are people that say they can't quit.

But I believe if you want to quit, as the head of our chairman of the British Medical Society I read a quote where this individual said from his point of view cigarette smoking was a habit, a doctor that's
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the head - the chairman of the British Medical Society believes that smoking is a habit, and if people want to quit, they can quit today.

Q. Well, I want you to assume that in the Engle class we represent people with Buerger's disease.

And hopefully your father quit smoking before he ever developed that.

And Buerger's disease is a circulatory condition where people start to lose fingers, toes and sometimes they lose arms, legs, and the doctors believe that this is caused by cigarette smoking, cause and effect clear to the doctors.

And I want you to assume that a doctor tells the patient who has lost some fingers and toes you keep smoking, you're going to lose your arm, you're going to lose your leg and the smoker believes the doctor, keeps on smoking, loses an arm, loses a leg, that guy's addicted, isn't he, or is he just weak?

MR. WEBER: I object to the form of the question.

A. I certainly have empathy for people that have those illness or those kinds of diseases.

But to me, as with my father, when he was
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told that the implication of his continued smoking would be to lose his hands and feet, he quit. He had smoked for 20 some years and he quit.

And so it is my view that if somebody wants to quit smoking, they will quit.

The situation you portray here to me doesn't sound substantially different than somebody that's told by a doctor that you have very high cholesterol, you're 50 pounds overweight, you need to reduce your fat consumption, you need to watch your diet, you need to exercise or you'll have a heart attack, and they continue on in that same mode of eating too much fat and not reducing their weight and not exercising.

Are you suggesting that those people are addictive - addicted to food?

I mean, that's the same parallel, where a doctor's telling them you need to stop, change your behavior or you're going to have health consequences, and they continue doing it, with regard to food.

Q. So the guy who's losing fingers and losing toes and who believes the reason he's losing fingers and toes is because he's smoking cigarettes, wants to stop and can't stop, you're telling us he just hasn't made a decision, a firm commitment to
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1 stop, because once he makes that firm commitment he
2 can do it like your father did it?

3 A. - I believe that he can make that -
4 commitment or that person and they can stop.
5 Just like the person who has a problem
6 with cholesterol can stop if they want to.

7 If they choose not to in spite of
8 doctor's advice, I don't believe anyone's portrayed
9 those people as being addicted to food or to
10 hamburgers.

11 Q. I'd like to show you Plaintiff's Exhibit
12 15.

13 (Whereupon, the above referred to
14 document was marked as Plaintiff's Exhibit No.
15 15 for Identification.)

16 Q. This is an RJR interoffice memorandum
17 from D. H. Piehl, P-I-E-H-L, to Dr. A. H. Laurene,
18 L-A-U-R-E-N-E.

19 Who are these people?
20 Do you know Piehl, do you know Laurene?

21 A. I knew - it's Andy Laurene. He was -
22 when I was with the company - somewhere in the late
23 '70s he became the head of research and development.
24 I don't know that he was in '71, but he eventually
25 became the vice-president of research and development.

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1 And Don Piehl, Don became a director of
2 research and development.

3 I'm not sure what their titles were.

4 Q. Back then?

5 A. Back in '71.

6 Q. Is he still with the company?

7 A. No. Neither of these individuals are.

8 Q. Okay. Second paragraph where it says
9 objective, quote, the ultimate objective is to develop
10 new product concepts that fulfill needs for the
11 nonsmoker, end quote.

12 Doesn't that mean from a business
13 standpoint we've got to figure out ways to get the
14 nonsmoker to start smoking?

15 If it doesn't mean that, what does it
16 mean?

17 A. I don't know what it means.

18 I mean, I've never seen this document
19 before. I've just now seen that sentence.

20 I don't know what that means based on
21 reading that sentence.

22 Q. I'm handing you now a document consisting
23 I believe of 27 pages, produced by RJR Tobacco Company
24 in the Butler case. This came up on a deposition.
25 Plaintiff's Exhibit 16.

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1 MR. WEBER: Get an extra of that one?

2 MS. ROSENBLATT: That one I think we do.

3 (Whereupon, the above referred to
4 document was marked as Plaintiff's Exhibit No.
5 16 for Identification.)

6 Q. Have you seen this before?

7 A. No, I haven't.

8 MR. WEBER: Thank you, Susan.

9 Q. I don't think that this has page numbers.

10 A. My copy doesn't. It has line numbers.

11 Q. Yes.

12 Let me find, so we'll be on the same

13 page --

14 MR. WEBER: What are the last four digits
15 on that page?

16 THE WITNESS: 2625.

17 MR. WEBER: Okay. Thank you.

18 Q. Now, this apparently is a Brown &
19 Williamson document.

20 I've pointed you to the section on
21 questions and answers.

22 And if you look at the last sentence in
23 the second paragraph on that page, the following
24 questions and answers are not intended to make
25 spokespersons out of Brown & Williamson employees but

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1 they are intended to better inform our managers.
2 And obviously this is a list of suggested
3 answers to commonly asked questions.

4 Now, look at the very first question,
5 does smoking cause lung cancer emphysema,
6 cardiovascular disease and bronchitis?

7 And the suggested answer is, no one
8 knows. Scientific research has not established that
9 smoking causes illness. We all know some scientists
10 have said smoking causes illness, but many respected
11 scientists believe cause has not been shown. More
12 research is needed.

13 And as - I've read that correctly?

14 A. (Witness nods).

15 Q. Okay. As I've understood your testimony,
16 Reynolds does not have a similar format in terms of a
17 employee handbook or in terms of communicating
18 information to employees as to how they should respond
19 to perceived attacks on the company?

20 MR. MOSS: Object to the form of the
21 question and move to strike everything until
22 the last sentence, which I think finally was a
23 question.

24 Q. You can answer?

25 A. Could you do the last sentence for me
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1 again?

2 (Thereupon, the requested portion of the
3 record was read back as above recorded.)

4 A. I don't know of any employee handbook.

5 Well, let me - this is Brown &

6 Williamson. I mean, I do work for R. J. Reynolds.

7 Q. Yes. But on a deposition it was produced
8 by RJR Tobacco Company in the Butler case.

9 Do you know how that happened?

10 A. I have no idea.

11 Q. Okay. You don't know how or if this ever
12 came into the possession of your company?

13 A. No.

14 I've never seen this before.

15 Q. Okay.

16 A. This is a Brown & Williamson employee
17 handbook.

18 Is that what you're referring to?

19 Q. That's what it says. Yes.

20 A. I don't know of any employee handbook
21 that we have that's similar to this.

22 Q. Plaintiff's Exhibit 17.
23 (Whereupon, the above referred to document
24 was marked as Plaintiff's Exhibit No. 17 for
25 Identification.)

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1 MR. WEBER: How about that one, do you
2 have a copy, Susan?

3 MS. ROSENBLATT: No.

4 MR. ROSENBLATT: So demanding.

5 MR. WEBER: It's just common courtesy.

6 I'm surprised you didn't have that for us.

7 I'm not smiling about it. It is an issue
8 of courtesy and I would have expected --

9 MR. ROSENBLATT: Courtesy's got nothing
10 to do with it. We're a small office. It was
11 an oversight.

12 MS. ROSENBLATT: We offered to make
13 copies. If you want to take a break for ten
14 minutes we can make some copies.

15 MR. WEBER: Not now. I'm going to -
16 Stanley's on a roll. We're going to let him
17 finish up.

18 Q. (By Mr. Rosenblatt) Okay. So
19 Plaintiff's Exhibit 17 is now in front of you. It's
20 an inter-office memorandum referring to nicotine
21 research, a memo from W.M. Henley to Dr. D. H. Piehl.

22 You've told us who Piehl is.

23 Who is Henley?

24 A. I don't know.

25 Q. Okay. Go to the second page, please.
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1 Now, the memorandum, the subject of the
2 memorandum is nicotine research; correct?

3 A. Yes.

4 Q. Going to the second page, the middle of
5 the page under the topic absorption, metabolism and
6 excretion, the first sentence says, probably the most
7 effective method of administering nicotine to the body
8 is by inhalation of cigarette smoke.

9 Do you agree with that?

10 A. There's nicotine in cigarettes and when
11 you smoke them they get to the body, inside the body,
12 obviously from the smoke.

13 I'm not a scientist so I can't possibly
14 comment on effective methods of administration of
15 nicotine to the body.

16 MR. ROSENBLATT: Plaintiff's Exhibit 18.

17 (Whereupon, the above referred to
18 document was marked as Plaintiff's Exhibit No.
19 18 for Identification.)

20 Q. (By Mr. Rosenblatt) Now, this document
21 which I've handed you, Plaintiff's Exhibit 18, is
22 titled Update on the Smoking and Health Issue and
23 Smoking Satisfaction from Murray Senkus to Mr. J.F.
24 Hind.

25 Do you know these men?

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1 A. I knew Jim Hind - well, I knew who he
2 was. He was a previous back in the '70s one of the
3 marketing directors.

4 Murray Senkus is one of the senior
5 research and development people.

6 Q. Go to the first page of text after the
7 table of contents. Yes. That page, the bottom
8 paragraph on that page, which I'm going to quote now,
9 regardless of the reports in the press or in the
10 medical journals claiming that the relationship
11 between smoking and health has been proven, the
12 tobacco industry in America does not accept those
13 claims. The tobacco industry and in particular the
14 management of R.J. Reynolds Tobacco Company maintain
15 that the relationship is still an open question.

16 Have I read that accurately?

17 A. Yes.

18 Q. That is - that it remains the position of
19 the R.J. Reynolds Tobacco Company as we sit here on
20 April 14, 1997; is that correct?

21 A. As I've testified before, that I believe
22 that cigarette smoking may cause the diseases that are
23 associated with smoking behavior. It is a risk factor
24 for those diseases.

25 Q. Mr. Schindler, the Broin case, which is
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1 the flight attendant class action, is going to trial
2 in Miami on June 2nd of this year.

3 Do you intend to appear personally at
4 that trial as a witness?

5 MR. WEBER: Let me object to that.

6 And I'll instruct him not to answer.

7 The decisions on witnesses will be made
8 by counsel.

9 Q. If it was your desire in a case where
10 R.J. Reynolds Tobacco Company was a defendant to
11 testify in person in front of a jury, no one could
12 stop you from doing that, could they?

13 MR. WEBER: Let me object to the
14 question.

15 Go ahead and answer, if you can.

16 A. I - if I testified in a case, it would be
17 with consultation with my attorneys.

18 Q. Okay. So that decision would be made by
19 your lawyers as to whether or not you'll come to Miami
20 and testify in this case?

21 A. In consultation with my lawyers.

22 Q. Okay. If I'm in trial in this case, the
23 Broin case, and you don't show up during the trial,
24 then I will have the right to assume that you in
25 consultation with your lawyers decided not to show up?

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1 MR. WEBER: Let me object to that. You
2 don't know what his schedule is going to be,
3 what the timing is, all sorts of issues there;
4 Stanley.

5 You can always play this tape and have
6 him there.

7 MR. ROSENBLATT: Plaintiff's Exhibit 18

8 (Whereupon, the above referred to
9 document was marked as Plaintiff's Exhibit No.
10 19 for Identification.)

11 Q. (By Mr. Rosenblatt) Okay. This document
12 is called Research Planning Memorandum on the Nature
13 of the Tobacco Business and the Crucial Role of
14 Nicotine Therein.

15 And this is an RJR document; correct?

16 A. That's what's stamped on the front.

17 Q. Okay. Go to page five, please.

18 MR. WEBER: Do we have a date on this,
19 Stanley?

20 THE WITNESS: '72, April 14, '72. It's a
21 Claude Teague memo.

22 MR. MOSS: What did you say the date was?

23 THE WITNESS: April 14, '72.

24 Q. Twenty-five years ago today, April 14,
25 '72.

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1 A. Yes.

2 Q. Go to page five, please.

3 MS. ROSENBLATT: The yellow tab, the
4 first yellow tab.

5 A. I'm there.

6 Q. Tell us who Mr. Teague is again?

7 A. He was in research and development.

8 Q. Okay. Now, are we on the same page,
9 five?

10 A. Yes.

11 Q. Okay. Starting right about here?

12 A. Yes, sir.

13 Q. Okay. Quoting, what we should really
14 make and sell would be the proper dosage form of
15 nicotine with as many other built-in attractions and
16 gratifications as possible, that is, an efficient
17 nicotine delivery system with satisfactory flavor,
18 mildness, convenience, cost, et cetera. On the other
19 hand, if we are to attract the nonsmoker or
20 pre-smoker, there's nothing in this type of product
21 that he would currently understand or desire. We have
22 deliberately played down the role of nicotine, hence
23 the nonsmoker has little or no knowledge of what
24 satisfactions it may offer him and no desire to try
25 it. Instead, we somehow must convince him with wholly
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1 irrational reasons that he should try smoking in the
2 hope that he will for himself then discover the real
3 satisfactions obtainable.

4 And, of course, in the present
5 advertising climate our opportunities to talk to the
6 pre-smoker are increasingly limited and therefore
7 increasingly ineffective.

8 Would it not be better in the long run to
9 identify in our own minds and in the minds of our
10 customers what we are really selling; i.e., nicotine
11 satisfaction.

12 This would enable us to speak directly of
13 the virtues of our product to the confirmed smoker and
14 would educate the pre-smoker perhaps indirectly but
15 effectively in what we have to offer and what it would
16 be expected to do for him.

17 Now, you would agree, would you not, that
18 based on what I just read that --

19 Is it Mr. Teague or Dr. Teague?

20 Was he a Ph.D. in something?

21 A. I'm not sure.

22 Q. Okay. You would agree from what I just
23 read that what he is saying is that nicotine is the
24 whole ball game in terms of smoking?

25 You may not agree with it, but that's
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1 what he's saying, nicotine is the key to keeping
2 smokers using our product and to attract new smokers,
3 if they knew the satisfactions of nicotine? -

4 MR. WEBER: Let me object to the form.
5 You can answer.

6 A. Do you want to repeat that, please?

7 (Thereupon, the requested portion of the
8 record was read back as above recorded.)

9 Q. That's the thrust of what I just read,
10 isn't it?

11 A. That's your interpretation.

12 Q. What's your interpretation?

13 A. My reaction, I've never seen this before,
14 I've been in this business a long time and, quite
15 frankly, with all due respect to the author, this
16 whole thing strikes me as bizarre.

17 Q. Your reaction is, you wish he never would
18 have wrote that?

19 A. No.

20 Q. Because it's harmful to your position in
21 having to explain how someone in a high post in
22 research and development could say what I just read in
23 an RJR document?

24 A. He wrote it. He wrote it 20 --

25 Q. Twenty-five years ago?

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1 A. -- as you pointed out, 25 years ago.

2 He's entitled to his point of view.

3 I think it's bizarre. I've never viewed
4 the product this way in my entire time with the
5 company and have never talked to anybody that did.

6 So maybe this is a little bit like the
7 McMahon issue with the sales force, you have an
8 employee here that has a point of view that I think is
9 completely bizarre.

10 Q. Well, actually, Teague was the director
11 of research and development.

12 A. He was - his last job, okay, when he left
13 the company was a director over planning and
14 administration. He was never the director of research
15 and development. And I believe, because this was in
16 1972, he was a manager several levels down in the
17 organization, would be my guess.

18 Q. Okay. But obviously he got promoted
19 after?

20 A. He was never the director of research and
21 development.

22 Q. Okay. But he got promoted --

23 A. To an administrative job.

24 Q. Okay.

25 A. Not a core research job as a director, as

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1 I remember it.

2 Q. Was that revealed to the government or
3 the public, what I just read from Mr. or Dr. Teague?

4 A. Was --

5 Q. What I just read, was that revealed that
6 those were his beliefs?

7 A. I have no idea.

8 Q. Okay. Now, go to the next page, page
9 six, about five lines down.

10 If his - if as proposed above nicotine is
11 the sine qua non of smoking, and if we meekly accept
12 the allegations of our critics and move toward
13 reduction or elimination of nicotine from our
14 products, then we shall eventually liquidate our
15 business, end quote.

16 And my question to you, sir, is, doesn't
17 this strike you as an honest bottom line statement
18 from a man who is simply speaking a simple truth,
19 which is, that if cigarettes contained zero nicotine,
20 there wouldn't be any smokers or there would be so few
21 smokers that nobody would make a profit?

22 A. This is Claude Teague's opinion.

23 Q. But I didn't hire him, you did.

24 A. I didn't hire him, either.

25 Q. But he's working for your company. And

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1 he wasn't fired after writing this, he was promoted.

2 A. That - nevertheless he wrote this, it's
3 his opinion.

4 This isn't a company position. This
5 isn't my position. I've never heard anybody say
6 things like that, other than in this document, and
7 I've been in this business a long time.

8 Q. How long was Teague in this business?

9 A. I believe he retired somewhere in the mid
10 '80s, so I would - I don't know. 25 years, 30 years.
11 I don't know how much time he had with the company
12 when he retired.

13 Q. Well, isn't --

14 A. His opinions are his opinions.

15 Q. Isn't --

16 A. This isn't my opinion.

17 Q. Well, has there ever been in the history
18 of the tobacco industry a cigarette that was marketed
19 and successful that did not contain nicotine?

20 A. Philip Morris had a product, I guess
21 essentially very little or no nicotine that they
22 attempted to market several years ago, and were highly
23 criticized by the anti's for doing it.

24 Q. Named what?

25 A. I can't remember.

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1 Q. You can't remember?

2 A. Yes. There was a product that they had
3 developed and marketed and were criticized at the time
4 for trying to do it.

5 Q. You can't remember it because it bombed,
6 it was a total failure?

7 A. It did not succeed in the marketplace.
8 That's right.

9 MR. ROSENBLATT: Plaintiff's Exhibit 20
10 (Whereupon, the above referred to
11 document was marked as Plaintiff's Exhibit No.
12 20 for Identification.)

13 Q. (By Mr. Rosenblatt) This is an RJR
14 document entitled Planning Assumptions and Forecast
15 for the Period Through 1986.

16 A. What's the starting place here?
17 It must be '76.

18 Q. '76.

19 A. The document is March of '76.

20 Q. Right. It's from the research
21 department, it's dated March 15, 1976.

22 Going to the first tab --

23 A. This it?

24 Q. Key issues of R.J. Reynolds Tobacco
25 Company.

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1 MR. WEBER: Just --

2 A. I'm not sure --

3 MR. WEBER: Wait just a second,
4 Mr. Schindler.

5 Just for the record, if you are going to
6 refer to tabs, Stanley, those aren't original
7 tabs that the author of the company put, those
8 are tabs that you put on.

9 MR. ROSENBLATT: Correct, to make it
10 easier for the witness.

11 MR. WEBER: Thank you.

12 Obviously try to answer his question. If
13 you need to read either before or after the
14 tab, I'm sure he'd want you to do that as well.

15 Q. (By Mr. Rosenblatt) Are you with me on
16 that page?

17 A. (Witness indicates).

18 Q. Right.

19 Number 12 says, the southern United
20 States would show the fastest growth in industry
21 volume.

22 Number 13 says, blacks will become a more
23 important segment of the cigarette business.

24 Well, that's certainly proved true,
25 hasn't it?

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1 A. I don't know. I don't know the trends in
2 African American smoking from 1976.
3 Q. -And 14 says, females will continue to
4 become a more important portion of the smoking
5 population.
6 That's certainly proved true, hasn't it?
7 A. I don't know the statistics from '76 to
8 now, 21 years ago.
9 Q. Now, the next tab is, the title is Key
10 Issue Position Paper.
11 A. Okay.
12 Q. Number one, trend issue or event
13 identified described, black will become a more
14 important segment of the cigarette business.
15 Number two, what will happen, black
16 population of smoking age will grow faster than total
17 population and Kools's hold on preferences should
18 weaken dash an opportunity.
19 Is it fair to say that what is expressed
20 here is that for some reason African Americans were
21 smoking a lot of Kools and R.J. Reynolds was
22 describing methods of how to get some of the Kool
23 smokers to the R.J. Reynolds brands; is that how you
24 interpret it, or differently?
25 A. I don't - talking about African American
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1 and they're talking about Kool, I don't see any
2 description of methods on how to get African Americans
3 to smoke our product.
4 Q. What does it mean when it says an
5 opportunity?
6 A. That's a theory, not a method.
7 Q. Okay. And then the next tab is a key
8 issue position paper that females will --
9 A. Wait a minute. I'm not sure - okay.
10 Q. That females will continue to become a
11 more important portion of the smoking population.
12 Now, I mean, this is the kind of thing
13 that the tobacco industry keeps close tabs on, isn't
14 it, for example, R.J. Reynolds knows and pays
15 attention to the number - the percentage of people who
16 smoke in China or in Russia; correct?
17 A. I've never seen numbers on China and
18 Russia.
19 Q. In what countries is smoking more popular
20 than the United States?
21 A. The only one that I suspect I have
22 knowledge of is perhaps in Japan, I believe there's a
23 higher incidence of smoking, but I've - you know, I'm
24 responsible for domestic US market.
25 Q. But you're not ignorant to the world
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1 market?
2 A. I don't study the world market.
3 I mean, you're asking me about China and
4 Russia and I'm responsible for the US.
5 Q. Now, go to the next tab, please, where
6 again at the top it's key issue position paper.
7 The number one, adult smokers under 25
8 will show a major shift in brand preference.
9 Number five, at the bottom, says source
10 NFO share of smokers shows that Marlboro's acceptance
11 among 14 to 17 year olds has dropped from 39 percent
12 to 32 percent. This pattern has been repeated by
13 three brands, with Pall Mall peaking in 1969, total
14 Winston in 1970 and total Marlboro should peak share
15 in 1978.
16 Have I read that correctly?
17 A. Uh-huh.
18 Q. So why do you figure RJR is discussing
19 14 to 17 year old smokers if that age group is
20 irrelevant to Reynolds?
21 Why is it even being discussed?
22 A. I don't know.
23 You've got a document here that is 40
24 pages or so, you're taking excerpts out of this,
25 they're referring to data, NFO share of smokers 25
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1 years ago or whatever, and you're picking out bits and
2 pieces.
3 I have no idea what this is doing or what
4 it's for.
5 Our policy is not to sell cigarettes, as
6 we've discussed before, to people under the legal age.
7 That is our policy, that is what we do.
8 And the relevance of this particular
9 document to our company policy is kind of lost on me
10 as you pick through each piece of this.
11 MR. WEBER: Stanley, we're at 5:20 now,
12 so if we can wrap up.
13 MR. ROSENBLATT: My estimate might have
14 been wrong.
15 MS. ROSENBLATT: The next tab.
16 Q. (By Mr. Rosenblatt) The last page, I
17 think. Where in the outer margin it says happening
18 now, in the middle of the page.
19 Are you with me?
20 What is the level of advertising
21 promotion spending required to maximize volume, by
22 brand, by brand style, new versus established.
23 In that context, what does that mean, new
24 versus established?
25 A. I'm not sure what they meant, but it
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1 sounds to me like new brands versus established
2 brands.
3 Q. Doesn't it mean new versus established
4 smokers?
5 A. You're either a smoker or you're not, so
6 I don't --
7 I don't know what you're talking about,
8 Mr. Rosenblatt.
9 Q. You would agree, would you not, that ever
10 since you've been with Reynolds in any capacity up
11 until the present time that any time a negative
12 scientific study comes out and gets any publicity in
13 the media, that the policy of Reynolds either directly
14 or through the Tobacco Institute is to criticize and
15 find fault with the study?
16 A. That's a very broad statement you're
17 making, any.
18 If something is published with regard to
19 our business and we have a different point of view, we
20 will state our different point of view.
21 Q. As a matter of fact, isn't that precisely
22 why and one of the main reasons for the existence of
23 the Tobacco Institute?
24 I mean, that's one of their mandates,
25 isn't it?
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1 MR. WEBER: Object to form.
2 A. Mandate to what?
3 Q. To look at literature, Surgeon General's
4 reports, EPA reports, World Health Organization
5 reports, American Cancer Society reports, that speak
6 negatively about cigarettes causing disease and death,
7 to have a come back, to respond to those reports which
8 are adverse to the financial health of the tobacco
9 industry?
10 MR. WEBER: Object to the form.
11 You can answer.
12 A. I've never viewed the Tobacco Institute
13 that way.
14 With regard to the science surrounding
15 our product, I rely on our research and development
16 people. I certainly don't rely on the Tobacco
17 Institute for keeping abreast of current science. I
18 really on that our R & D people, not the Tobacco
19 Institute. That thought never crossed my mind.
20 Q. That's not what I was asking you.
21 I was asking you what organ or entity of
22 the tobacco industry responds when, for example, a
23 Surgeon General's report comes out in 1988 saying that
24 smoking's addictive?
25 A. What entity responds?
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1 Q. Yes.
2 Is it the Tobacco Institute?
3 A. Depends on the situation.
4 Q. Okay. That situation, the ADA --
5 A. I don't know what the Tobacco Institute
6 said in 1988.
7 Q. What did you say?
8 A. I'm --
9 Q. Obviously you said --
10 MR. WEBER: Stanley, let him finish.
11 A. I was working in the foods business in
12 1988.
13 You're asking a very broad question about
14 I believe the Tobacco Institute. I have no idea what
15 the Tobacco Institute said in 1988 with regard to the
16 Surgeon General's report and addiction.
17 Q. Mr. Schindler, you are the
18 president and CEO of R.J. Reynolds Tobacco
19 Company?
20 A. Yes, sir.
21 Q. And I am asking you what your company -
22 how your company responded to the 1986 Surgeon
23 General's report, for example, on environmental
24 tobacco smoke, to the 1988 Surgeon General's report
25 saying that smoking was addictive?

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1 You're telling me you don't know?
2 A. I don't - I wasn't in this position, I
3 wasn't in the position --
4 Q. You've never studied?
5 A. To go back these years and evaluate prior
6 responses to Surgeon General's reports that the
7 company may have had made ten, 12, 13, 14, 20, 45
8 years ago? No, I haven't done that.
9 Q. But you do know, don't you, even though
10 you may not know the particulars or the details, you
11 certainly know that R.J. Reynolds Tobacco Company just
12 did not sit with its hands folded when those Surgeon
13 General's reports came out, you know, I assume, that
14 R.J. Reynolds Tobacco Company responded and in some
15 way found fault with or pointed out the inaccuracies
16 or the improper methodologies of those reports, don't
17 you?
18 A. Well, the company would react to those
19 reports as it saw fit and take positions that it felt
20 it had a right to take.
21 Q. Well, if the Journal of the American
22 Medical Association took an editorial position that
23 everyone knows, everyone knows and everyone accepts
24 with the exception of the tobacco industry that
25 cigarette smoking causes cancer and that environmental

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1 tobacco smoking causes cancer and let's stop this
2 nonsense of acting and pretending as though this were
3 a debatable or controversial issue when it is
4 absolutely not, what would you direct your people, how
5 would you direct your people to respond to such an
6 editorial in the Journal of the American Medical
7 Association?
8 MR. WEBER: Object to the form of the
9 question.
10 You can go ahead.
11 A. Again, this is one of your very
12 theoretical, hypothetical questions.
13 The example you throw out here, I might
14 not direct anyone to do anything if the Journal of the
15 American Medical Association wrote an editorial as you
16 described it such as that.
17 Q. Well, how about if the editorial that
18 I've just suggested in my according to you
19 ridiculous hypothetical was carried on the front page
20 of every paper in the country.
21 Certainly R.J. Reynolds Tobacco Company
22 would respond in some fashion?
23 A. Not necessarily.
24 Q. What's the policy on that?
25 Is there no policy, it's just hit or

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1 miss?
2 A. What you described sounds to me - I don't
3 see any reason that you would respond. You're asking
4 a hypothetical question. I'm saying to you that it is
5 not necessarily true that there would be any response
6 to that.
7 Q. What was the response of the RJR Tobacco
8 Company to the US - United States Environmental
9 Protection Agency's report on secondhand smoke?
10 A. Our response was that they were invalid
11 in their judgment, that the epidemiology has not
12 supported the judgment that they made, and the
13 epidemiology since then has confirmed our position
14 even stronger.
15 Q. Name one study, you're talking generally
16 about epidemiology, name one study, name one author
17 which has, as you say, weakened the findings of the
18 EPA report saying very clearly that environmental
19 tobacco smoke is a Class A carcinogen and that 3000
20 lung cancer deaths are caused every year to America
21 as a result of breathing in involuntary smoke?
22 A. The Congressional Research Service, an
23 independent research service that provides expertise
24 in the evaluations to Congress questioned quite
25 strongly the valid of their judgment.

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1 The epidemiology, as I understand it, has
2 continued, has driven whatever risk has been in the
3 original epidemiology down to an even lower level.
4 Everything that I have seen in review
5 with our scientists points in the direction that
6 there's not sufficient epidemiological research to
7 justify the claim that's been made by the EPA.
8 MR. WEBER: Stanley, we've been going
9 hour now since on our last break and we're
10 since we last started. We're past when we
11 thought we were going to quit. I guess we're
12 going to have to take a break.
13 How much longer are you going to go?
14 MR. ROSENBLATT: Less than a half hour.
15 MR. WEBER: We had people making plan
16 changes based on the fact you said you'd be
17 done by 5:20. We figured 5:30.
18 Any way you can get this done in the next
19 few minutes?
20 MR. ROSENBLATT: You know, I'll do my
21 best during the break. I'll talk to my wife.
22 I'll see what I can streamline.
23 MR. WEBER: Okay. We'll be back in about
24 two minutes.
25 (Whereupon, a short break was taken.)

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1 Q. (By Mr. Rosenblatt) Is it in your
2 opinion a legitimate concern of government to provide
3 information to the American people to protect them
4 from involuntary exposure to a hazardous substance?
5 A. It's the legitimate role of government
6 from my standpoint to inform people of what they think
7 risks are in their environment or in society.
8 Q. The Frank Statement To Cigarette Smokers
9 published in January, 1954, in every major newspaper
10 in America, says toward the bottom of the first
11 column, we accept an interest in peoples' health as a
12 basic responsibility, paramount to every other
13 consideration in our business.
14 Do you accept that responsibility today?
15 MR. WEBER: Let me object to the -
16 Mr. Rosenblatt's portion of that question about
17 where he testified about where it was
18 published.
19 You can go ahead and answer.
20 A. As I testified earlier, we have - you
21 asked me earlier responsibilities that we have, and
22 they're varied and one of those is to our smokers.
23 Q. Mr. Schindler, I read one sentence, I'm
24 asking if you agree with that sentence, we accept an
25 interest in peoples' health as a basic responsibility.

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paramount to every other consideration in our business.

Please don't refer me to your earlier testimony.

My question simply is, does R.J. Reynolds as we sit here today on April 14, 1997, accept an interest in peoples' health as basic responsibility, paramount to every other consideration in your business?

A. I view, you know, the issues regarding smoking in terms of health risks as a paramount importance in my doing my duty as a CEO.

Q. The last statement in that first section is, referring to the tobacco industry, we always have and always will cooperate closely with those whose task it is to safeguard the public health.

Is that the position of R.J. Reynolds Tobacco Company today, that you are and will cooperate closely with those whose task it is to safeguard the public health?

A. I believe we should cooperate.

Q. And you - and do you believe you have done so?

A. I believe we have done that up until the end of this '70s, when I believe under the Carter

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administration that a joint working group between public health officials and the industry was disbanded by the Carter administration, and since then it's become adversarial.

Q. What, if anything, do you have to say to the children of a heavy smoker of your products who dies of lung cancer prematurely, in their early 40s, and the kid comes to you and says your product killed my mother or your product killed my father, that's what the doctor says, that's what the literature says, what do you say to that kid, maybe it did and maybe it didn't?

MR. WEBER: Let me object to the question as being wholly argumentative.

Q. Because as I've heard your testimony all day long when we talk about risk factors, you've said over and over again maybe it causes cancer, maybe it doesn't.

So I'm saying what do you say to this kid, maybe my product killed your parent and maybe it didn't?

MR. WEBER: Same objection.

A. It's unfortunate in this hypothetical situation that you've created here that some child would lose their parent to a disease such as lung

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cancer.

My view, as I have stated in this deposition, that cigarettes based on the science of epidemiology are a risk factor related to lung cancer and other diseases and it may have caused, but it may not have.

Q. So Mr. Schindler, even if the child's mother died at 42 and was a three pack a day Camel smoker from the time she was 14 years of age, having the opinion and the viewpoint that you've expressed just now and throughout this deposition, you can go home with a clear conscience and you can go to the offices of R.J. Reynolds Tobacco Company tomorrow and continue your business with a clear conscience; correct?

A. Yes.

MR. ROSENBLATT: That's all I have.

MR. WEBER: Thank you.

(Thereupon, the taking of the deposition was concluded.)

KLEIN, BURY & ASSOCIATES, INC.

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Deponent

Sworn to and subscribed before me this _____ day of _____, 1997.

Notary Public

KLEIN, BURY & ASSOCIATES, INC.

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CERTIFICATE STATE OF FLORIDA:

SS:
COUNTY OF BROWARD:

I, Richard O. Applebaum, being a Shorthand Reporter and a Notary Public of the State of Florida at Large, do hereby certify that I reported the deposition of Andrew Schindler, called as a witness by the Defendant in the above-styled cause; that the said witness was duly sworn by me; that the witness thereafter read and subscribed said deposition; that the foregoing pages, numbered from 1 to 220, inclusive, constitute a true and correct transcription of my shorthand report of the deposition by said witness on this date.

I further certify that I am not an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action nor financially interested in the action.

WITNESS my hand and official seal in the City of Fort Lauderdale, County of Broward, State of Florida this 16th day of April, 1997.

RICHARD O. APPLEBAUM
KLEIN, BURY & ASSOCIATES, INC.

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KLEIN, BURY & ASSOCIATES, INC.

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Can we have an open debate about smoking?

The issues that surround smoking are so complex, and so emotional, it's hard to debate them objectively.

In fact, many of you probably believe there is nothing to debate.

Over the years, you've heard so many negative reports about smoking and health—and so little to challenge these reports—that you may assume the case against smoking is closed.

But this is far from the truth.

Studies which conclude that smoking causes disease have regularly ignored significant evidence to the contrary. These scientific findings come from research completely independent of the tobacco industry.

We at R.J. Reynolds think you will find such evidence very interesting.

Because we think reasonable people who analyze it may come to see this issue not as a closed case, but as an open controversy.

We know some of you may be suspicious of what we'll say, simply because we're a cigarette company.

We know some of you may question our motives.

But we also know that by keeping silent, we've contributed to this climate of doubt and distrust. We may also have created the mistaken impression that we have nothing to say on these issues.

That is why we've decided to speak out now, and why we intend to continue speaking out in the future.

During the coming months we will discuss a number of key questions relating to smoking and health. We will also explore other important issues including relations between smokers and non-smokers, smoking among our youth, and "passive smoking."

Some of the things we say may surprise you. Even the fact that we say them may prove controversial.

But we won't shy away from the controversy because, quite frankly, that's our whole point.

We don't say there are no questions about smoking. Just the opposite. We say there are lots of questions—but, as yet, no simple answers.

Like any controversy, this one has more than one side. We hope the debate will be an open one.

R.J. Reynolds Tobacco Company

51601 8385



Government is proposing to make it illegal for you to smoke in your own home anytime a workman or repairman visits. It's part of a massive effort to prohibit smoking or will allow the Government to make decisions for individual citizens that have always been matters of personal choice.

“COME OUT SLOWLY SIR, WITH YOUR CIGARETTE ABOVE YOUR HEAD.”

The situation above may seem implausible at first. But right now, the Government is trying to compare cigarettes to heroin and cocaine. They are also proposing to entirely prohibit smoking in public places, company cars, trucks and any place of business entered by ten or more people a week. These same proposals could also affect your private home as you could be forbidden to smoke anytime a workman or repairman visits. In addition, a cigarette tax increase of 300% is being considered.*

This is nothing less than an attempt at tobacco prohibition, something that will have serious implications for Americans.

Earlier this year, the Canadian Government was forced to rollback the exorbitant cigarette tax they introduced just two years ago. Organized criminal gangs controlled a huge smuggling market, creating a climate of fear and violence throughout the country. "Smuggling is threatening the safety of our communities... and the very fabric of Canadian society", the Canadian Prime Minister said when he announced the tax reductions. In 1993, up to two-thirds of the cigarettes smoked in Quebec were purchased illegally.**

California, which raised its cigarette taxes to fund health education, reports that 7% of the entire tobacco market consists of illegal cigarettes.*** Higher taxes will only make things worse.

Despite the Government's denials, the proposed tax increases and the avalanche of other anti-tobacco legislation are all simply forms of backdoor prohibition. The end result, should this legislation pass, could be disastrous. How will they enforce the law? Will the homes of 'known' smokers be raided? Will we be encouraged to inform upon our neighbors? Has the Government given any thought to the consequences?

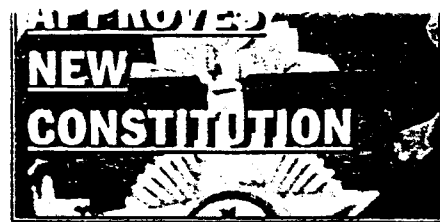
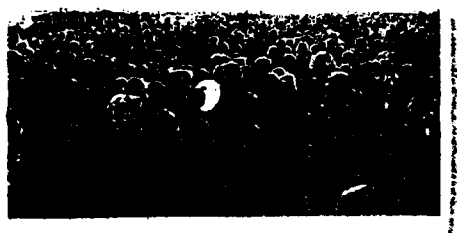
This opinion is brought to you in the interest of an informed debate by the R.J. Reynolds Tobacco Company. We believe that the answer to most smoking issues lies in accommodation, in finding ways in which smokers and non-smokers can co-exist peacefully. We encourage dialogue and discussion that will solve the issues without resorting to Government intervention.

For further information please call toll-free 1-800-366-8441.

TOGETHER, WE CAN WORK IT OUT



51601 8386



Democracy's Victory In South Africa

Free At Last: Mandela and ANC Celebrate Triumph



Nationwide, Reins on U.S. Smokers' Freedom Tighten

WHERE EXACTLY IS THE LAND OF THE FREE?

These days the cry of new-found freedom is heard in the world. Many countries are rejecting repressive regimes and embracing self-determination and the principles that we, in America, hold so dear. But, with the recent proposals, our own Government may be taking a serious step backwards.

The Government is attempting to prohibit smoking in America. They've proposed a substantial increase to make cigarettes too expensive for people to afford.¹ They've introduced regulations that could lead to a total smoking ban in private as well as public places in some circumstances.²

Regardless of their reasons, both their tactics and the end result they are seeking are threats to our freedoms. The individual rights of not just the 45 million Americans who choose to smoke, but other Americans as well, could be compromised.

If they are successful in their bid to abolish cigarettes will they then pursue other targets? Alcohol could be next. Will caffeine and high-fat

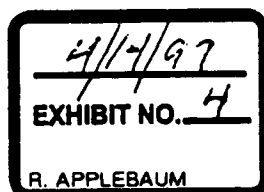
foods follow? Then books, movies and music? Who knows where it could end?

The time has come to say, 'enough'. The time has come to allow adults in this country to make their own decisions of their own free will, without Government control and excessive intervention. The time has come for a little common sense to prevail and for us to once again deserve to be called the land of the free.

This opinion is brought to you in the interest of informed debate by the R.J. Reynolds Tobacco Company. We believe that the solution to many smoking issues can be found in accommodation, finding ways in which smokers and non-smokers can co-exist peacefully. And we encourage dialogue and a discussion that will help solve the issues without resorting to Government intervention. For further information please call 1-800-366-8441.

TOGETHER, WE CAN WORK IT OUT

51601 8387





Judy Overholser, New Mexico: "I have a flower business, and I don't think it's fair for the Government to tell me that I can't smoke in my own shop. I say 'Give us a break.' They shouldn't control everything we do."



Andrew Bontje, Oklahoma: "I think anytime the Government intrudes into our personal lives it's detrimental to society. They shouldn't tell us what to do, they should stay out of our personal lives."



William Buhl, Illinois: "I think it should be up to the individual businesses, and their patrons, to decide what they want to do about smoking. The Government should keep their hands off."

EVERYWHERE WE GO, AMERICANS ARE TELLING US THEY WANT THE GOVERNMENT OFF THEIR BACKS.

These days, the Government is making more of the decisions that should rightfully be left to the individual. More than 125,000 Government employees are involved in regulating the American people, working on more than 5,000 regulations at any given time, at an estimated cost to the taxpayer of more than \$500 billion.¹ And from Savannah to Seattle, Americans have told us they've had enough.

"On The Road For Rights" has made more than 125 stops in cities, towns and villages across 15 states. We've spoken to thousands of ordinary Americans, smokers and non-smokers. They've talked to our video cameras. Signed petitions. Everywhere we've been, we've heard the same heartfelt cry: "It's time to get the Government off our backs."

Among the major rights at stake is the freedom of adults to choose to smoke. The Government is currently proposing to prohibit smoking in public places, company

cars, trucks and any place of business entered by 10 or more people a week. Your right to smoke in your own home could also be affected, as you could be forbidden to smoke anytime a workman or repairman visits.²

However, a recent poll confirms that 9 out of 10 Americans believe that adults should have the right to choose for themselves whether or not to smoke.³

We believe the solution to most smoking issues can be found in accommodation, in findings ways where smokers and non-smokers can co-exist peacefully. Through dialogue and discussion, we can agree on solutions without resorting to Government intervention.

These opinions are brought to you in the interest of an informed debate by the R.J. Reynolds Tobacco Company. For further information please call 1-800-366-8441.

TOGETHER, WE CAN WORK IT OUT.

51601 8388





Marta Kramer, Cedar Crest, NM, is a non-smoker. But she's angry with the Government's decision to pursue more and more legislation against smokers.

**"THE SMELL OF
CIGARETTE SMOKE ANNOYS ME.
BUT NOT NEARLY AS MUCH AS THE
GOVERNMENT
TELLING ME WHAT TO DO."**

"Today our Government is attempting to influence personal choices in ways I don't think they were ever supposed to. Their plans to further legislate against smoking represent a dangerous attempt to interfere with our personal lives and, as an American citizen, it concerns me. If the Government continues to be successful, smoking will be banned.

"The role of Government should be to inform. They should just give me information and allow me the freedom to make my own decisions. I would much rather have dialogue. I would much rather try everything else before we pass a law. We're going to ban something? Outlaw something? That's not what the United States is supposed to be like.

"Personally, I dislike smoking. But I acknowledge it's a personal pleasure and there are appropriate places to smoke. Polite behavior dictates that you don't smoke during dinner. You don't smoke in someone's house if they don't want you to.

"If you don't smoke, it is ill-mannered to go up and tell somebody that what they're doing is disgusting. My

smoke when we're eating and when we're in the car or something she opens a window. Thinking, reasonable adults accommodate one another. They certainly don't need the Government resolving that issue for them.

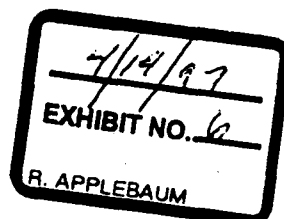
"We need to be careful about passing legislation. It's easy to pass, but very difficult to repeal. These issues deserve a lot more dialogue, a lot more thought. Legislation simply puts more power into the hands of the Federal Government and I just don't feel comfortable with that.

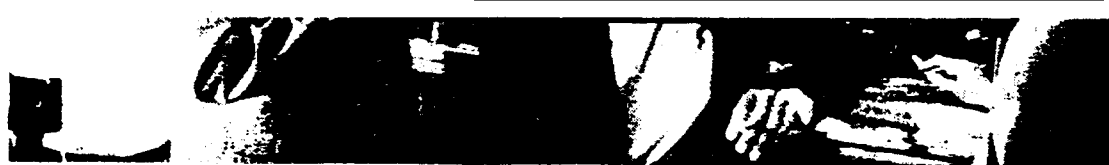
I think there are many Americans out there that will see Government intrusion into our private lives and reject it."

This opinion is brought to you in the interest of an informed debate by the R.J. Reynolds Tobacco Company. We believe the solution to most smoking issues can be found in accommodation, in finding ways in which smokers and non-smokers can co-exist peacefully. And we encourage discussion that will help solve the issues without resorting to Government intervention.

For further information please call 1800-366-8441.

51601 8389





IS THE GOVERNMENT GOING TOO FAR?

Believe it or not, there is a possibility that the government will be successful in its drive to get smoking banned in America. Obviously this amounts to prohibition. If this sounds unlikely, consider the following.

The government is currently proposing to ban smoking in any building being entered regularly by ten or more people at least once a week (which includes just about every workplace in the country) unless a specially ventilated and separately exhausted area specifically designated for smoking is provided. Obviously this regulation will apply to every restaurant and bar in America. But that's not all.

Government regulation could also affect your home. Your right to smoke in your home could be curtailed anytime a delivery person or a service person was present.

Private vehicles could also be affected. If you are a

trucker or a salesman you may not be permitted to smoke in your truck or car even if you are alone.

The time has come to say, "enough". The time has come to allow adults in this country to make their own decisions of their own free will, without government control or government intervention.

This opinion is brought to you in the interests of an informed debate by the R.J. Reynolds Tobacco Company. We believe that the solution to most smoking issues can be found in accommodation, in finding ways in which smokers and non-smokers can co-exist peacefully. And we encourage dialogue and discussion that will help solve the issues without the government mandating behavior. For further information please call us at 1-800-366 8441.

REYNOLDS TOBACCO COMPANY

51601 8390





SECONDHAND SMOKE: HOW MUCH ARE NON-SMOKERS EXPOSED TO?

With all the discussion today about secondhand smoke, you may be interested in how much you are exposed to.

The answer, in our opinion, is very little. Expressing exposure to secondhand smoke in terms of cigarette equivalents is one way to gain a perspective. For example:

1) In a month, a non-smoker living with a smoker would, on average, be exposed to secondhand smoke equivalent to smoking approximately 1 1/2 cigarettes.*

2) In a month, a non-smoking waiter who works eight hours a day, five days a week in a restaurant would, on the average, be exposed to secondhand smoke equivalent to smoking about 2 cigarettes.*

3) In a month in a modern office where smoking was permitted, a non-smoker sharing an office with a smoker would, on average, be exposed to the equivalent of smoking about 1 1/4 cigarettes.*

There are many ways to calculate cigarette equivalents, and no method exactly predicts the precise amount of secondhand smoke a non-smoker is exposed to.

Also, cigarette equivalent calculations are

not necessarily relevant to an assessment of the potential risk from secondhand smoke.

In our opinion, secondhand smoke is not the same as the smoke a smoker inhales.

What we are saying is that there are always two sides to every argument. Both sides need to be heard and evaluated in order to make an informed decision.

We believe that the solution to most smoking issues can be found in accommodation. There are ways for smokers and non-smokers to co-exist peacefully. And we encourage discussion that will help solve the issues without resorting to Government intervention. Clearly common sense should tell everyone not to expose very young children to high levels of secondhand smoke.

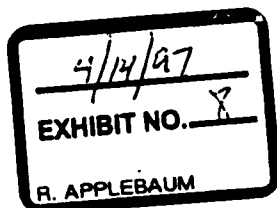
As it relates to smokers, in our opinion smoking is a risk factor for certain diseases. At R.J.Reynolds we believe the choice to smoke should be made only by adults.

This opinion is brought to you in the interests of an informed debate by the R.J.Reynolds Tobacco Company. For further information please call 1-800-366-8441.

TOGETHER, WE CAN WORK IT OUT

51601 8391

*CALCULATIONS BASED UPON A PUBLISHED REVIEW OF AVERAGE SMOKING AREA MEASUREMENTS OF NICOTINE, ONE OF THE COMPONENTS USED BY MANY RESEARCHERS TO DEVELOP A SENSE OF THE MAGNITUDE OF SECONDHAND SMOKE EXPOSURE. USE OF OTHER COMPOUNDS MAY GIVE DIFFERENT RESULTS, AND AN INDIVIDUAL'S ACTUAL EXPOSURE MAY VARY SIGNIFICANTLY.



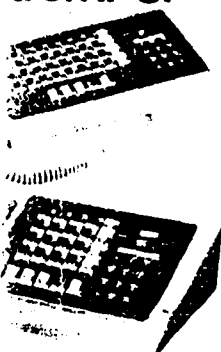
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shares outstanding at March 31, and that the Morgan Stanley stake "isn't significant" to the company.

Tax-Exempts

Sales

Miami Beach, Fla., issued \$22 million of improvement bonds at yields ranging from 6.5% in 1985 to 10.2% in 2001. The unsold balance late yesterday totaled about \$13.3 million, according to William H. Hough & Co., chief underwriter. Moody's Investors Service Inc. graded the issue single-A.

Windsor PPS \$1	254	17	80	52
Windsor PPS \$2	974	11	86	70
Windsor PPS \$3	174	18	79	87
Windsor PPS \$4	147	12	82	87
Windsor PPS \$5	15	17	80	70

Winners Corp. Warrants

NASHVILLE, Tenn. — Winners Corp. said its board voted to extend to Dec. 28 from June 30 the expiration date on its warrants outstanding to purchase common stock. The warrants can be exercised at \$9.75 a share. The company's common stock closed Tuesday at \$8.75, down 25 cents. Winners operates Mrs. Winner's Chicken & Biscuits Restaurants and Wendy's Old Fashioned Hamburger Restaurants.

Rates subject to change without notice and substantial interest penalties required for early withdrawal.

Mercury Savings

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Second-Hand Smoke: The Myth and The Reality.

Many non-smokers are annoyed by cigarette smoke. This is a reality that's been with us for a long time.

Lately, however, many non-smokers have come to believe that cigarette smoke in the air can actually cause disease.

But, in fact, there is little evidence—and certainly nothing which proves scientifically—that cigarette smoke causes disease in non-smokers.

We know this statement may seem biased. But it is supported by findings and views of independent scientists—including some of the tobacco industry's biggest critics.

Lawrence Garfinkel of the American Cancer Society, for example. Mr. Garfinkel, who is the Society's chief statistician, published a study in 1981 covering over 175,000 people, and reported that "passive smoking" had "very little, if any" effect on lung cancer rates among non-smokers.

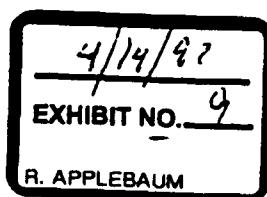
You may have seen reports stating that in the course of an evening, a non-smoker could breathe in an amount of smoke equivalent to several cigarettes or more.

But a scientific study by the Harvard School of Public Health, conducted in various public places, found that non-smokers might inhale anywhere from 1/1000th to 1/100th of one filter cigarette per hour. At that rate, it would take you at least 4 days to inhale the equivalent of a single cigarette.

Often our own concerns about our health can take an unproven claim and magnify it out of all proportion; so, what begins as a misconception turns into a frightening myth.

Is "second-hand smoke" one of these myths? We hope the information we've offered will help you sort out some of the realities.

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R.J. Reynolds Tobacco Company

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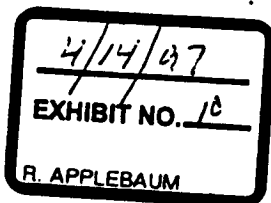
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STRATEGIC RESEARCH REPORT

February 29, 1984

TO: Mr. G. H. Long
Mr. M. L. Orlowsky
Mr. H. J. Lees

FROM: Diane S. Burrows

YOUNGER ADULT SMOKERS: STRATEGIES AND OPPORTUNITIES

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PUBLISHED BY THE MARKETING DEVELOPMENT DEPARTMENT
R.J. REYNOLDS TOBACCO COMPANY, WINSTON-SALEM, N.C. 27102

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MDD ABSTRACT FORM

PROJECT NUMBER		None
TITLE: Younger Adult Smokers: Strategies and Opportunities		
AUTHOR: Diane S. Burrows		
DATE STARTED: —		DATE COMPLETED: 2/29/84
TYPE OF RESEARCH: Strategic		SECTION MANAGER: R. C. Mordine
ABSTRACT: Younger adult smokers are shown to be critical to long term brand/company growth in the past, present, and future. Younger adult performance of the six major brands of the last half century was analyzed to identify four common strategies/circumstances leading to their younger adult strength. They capitalized on: 1. Changes in external factors. 2. Growth sectors among younger adult smokers. 3. Out-of-touch competitors. 4. Product mildness, communicated positively. Key recommendations include: 1. Establishment of a separate younger adult smoker program/unit, with customized procedures/measures, improved information resources, and a less competitor-centered focus. 2. Attention to Blacks, Hispanics, females, social acceptability, pricing, and potential enhancement of product acceptability.		

KEY WORDS

Younger Adult Smokers
 Fall Mall
 WINSTON
 Marlboro

Kool
 SALEM
 Newport
 Blacks

Hispanics
 Women
 Social Acceptability
 Pricing

Signature

2/29/84
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YOUNGER ADULT SMOKERS:
STRATEGIES AND OPPORTUNITIES

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YOUNGER ADULT SMOKERS:
STRATEGIES AND OPPORTUNITIES

MANAGEMENT SUMMARY

PURPOSE

This is intended to assist RJR in optimizing its strategic position with respect to younger adult smokers (18-24) by clarifying their importance versus smokers 25+, identifying strategies which have been most effective against younger adult smokers in the past, and applying this learning to RJR and its current environment.

This summary provides a broad overview of the most critical points and key ideas in the report. However, it was necessary to omit many important points in order to be brief, and readers are encouraged to read the entire document.

THE IMPORTANCE OF YOUNGER ADULT SMOKERS

Younger adult smokers have been the critical factor in the growth and decline of every major brand and company over the last 50 years. They will continue to be just as important to brands/companies in the future for two simple reasons:

- The renewal of the market stems almost entirely from 18-year-old smokers. No more than 5% of smokers start after age 24.
- The brand loyalty of 18-year-old smokers far outweighs any tendency to switch with age.

Thus, the annual influx of 18-year-old smokers provides an effortless momentum to successful "first brands".* Marlboro grows by about .8 share points per year due to 18-year-old smokers alone:

On the other hand, brands/companies which fail to attract their fair share of younger adult smokers face an uphill battle. They must achieve net switching gains every year to merely hold share. By not attracting its fair share of 18-year-old smokers, RJR yielded a .5 point ingoing share advantage to PM in 1983.

Marlboro and Newport, the only true younger adult growth brands in the market, have no need for switching gains. All of their volume growth can be traced to younger adult smokers and the movement of the 18-year-olds which they have previously attracted into older age brackets, where they pay a consumption dividend of up to 30%. A strategy which appealed to older smokers would not pay this dividend.

- * i.e., those which appeal to 18-year-old smokers rather than switchers ages 19-24.

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In every sense, companies with strong younger adult brands hold the high ground, standing above the increasingly difficult and costly battle for switchers. Today, only Philip Morris and Lorillard are growing among younger adult smokers; RJR is losing about a point per year among this group.

SUCCESSFUL YOUNGER ADULT BRAND STRATEGIES OF THE PAST

A review of the five key brands in the last half century — Pall Mall, WINSTON, Marlboro, Kool, and Newport — shows that each built considerable strength among younger adult smokers well ahead of its upsurge in market share. Their strategies succeeded almost invisibly, hidden from competitors in the critical but low-volume younger adult smoker market.

The positionings of these brands have all been very different, but there have been important similarities in the strategies they followed. While chance may have played a role in these past successes, the analysis indicates that the key elements can be understood and purposefully leveraged if sufficient time, priority, and resources are invested.

- All of these brands took advantage of changes in the external environment that worked against or were ignored by their predecessor. The external changes included smoking and health during the 1950's, the generation gap in the 1960's, and racial pride in the late 1960's-70's. These factors affected the mix of the younger adult smoker market as well as its mindset.
- All of the brands capitalized on demographic shifts within the younger adult smoker market. Females were gaining importance when Pall Mall and WINSTON took off. Marlboro made its inroads during the 1960's, the only decade when younger adult male smokers surged in importance. The emergence of younger adult Black smokers has been pivotal to Kool and Newport. These brands succeeded by keying on the growth sectors without boxing themselves in, e.g., Marlboro was as well developed among females as males until recent years.
- In every case, the major younger adult brands have been succeeded by a brand which was positioned to be different from its predecessor and better "in-touch" with the younger adult smokers of the time. Me-too strategies have never worked.
- All of these successful brands have stressed positive product messages (as opposed to problem/solution) and have provided milder/smoothier product delivery than their predecessor.

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IMPLICATIONS/RECOMMENDATIONS FOR RJR

1. Younger adult smokers are critical to RJR's long term performance and profitability. Therefore, RJR should make a substantial long term commitment of manpower and money dedicated to younger adult smoker programs. An unusually strong commitment from Executive Management will be necessary, since major volume payoffs may lag several years behind the implementation of a successful younger adult smoker strategy.

This time lag can also magnify the penalties for wrong turns in the development and implementation of younger adult smoker programs. To prevent such problems:

- RJR should develop objectives, planning procedures, and marketability criteria for younger adult brands/programs which reflect their unique, long term character. These may differ significantly from the approaches/measures which are appropriate to established brands or to new brands addressing older smokers by, for example, emphasizing consumer-based rather than volume-based action standards.
- RJR should make resources available to develop/improve its capabilities to thoroughly identify and track demographics, values, wants, media effectiveness, and brand performance within sectors of the younger adult smoker population. These tools will be critical to the development and implementation of effective programs addressing younger adult smokers.
- Because of the sensitivity of the younger adult smoker market, brand development/management should encompass all aspects of the marketing mix and maintain a long term, single-minded focus to all elements -- product, advertising, name, packaging, media, promotion, and distribution. Tactics which could negatively affect the integrity of the strategy should be avoided.

2. RJR should seek to better understand and capitalize on the factors/strategies which have succeeded for younger adult brands of the past. Since RJR's processes/tools have been better attuned to switching efforts than to "first brand" strategies, time and learning will clearly be required to fully assess the opportunities available through these avenues.

It should be noted that the new/established brand programs in the 1984 Plan already address the major issues/trends identified below, within the framework of current knowledge/processes. These Plans should continue as a basis for RJR's 1984 marketing efforts, but should be enhanced by a full-time dedication of resources to ensure a solution to the problem.

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- External factors of key interest are social acceptability, which could revolutionize the future market, and pricing, which has been critical in 1983. Both will require careful understanding and execution to reach younger adult smokers.
- The key demographic growth sectors among younger adult smokers are Blacks, Hispanics, and females. In terms of wants, the desire to "move up in the world" is likely to become even more intense, but expressed in more entrepreneurial ways. Based on history, these opportunities could be realized by brands with a balanced younger adult base as well as, perhaps, narrowly targeted ones.
- The key out-of-tough competitor is Marlboro, which now relies more on younger adult identity/belonging generated by its own users, rather than on the "masculinity" of its advertising. Marlboro is too broad (half the younger adult smoker market) to be addressed as a single competitor and should be attacked by a variety of younger-adult-centered rather than competitor-centered strategies. RJR should emphasize innovative points of difference from existing brands in attacking the younger adult smoker market, using head-on/imitative efforts primarily as defensive measures.

Philip Morris may have recognized Marlboro's vulnerability and be using it as a "feeder brand" for Virginia Slims and Merit. This increases these brands' importance as competitive targets.

Among RJR established brands, VANTAGE has the best switching performance versus Marlboro and may be able to maintain/enhance that performance.

- Product wants of younger adult smokers, especially mild/smooth/less harsh delivery, should be fully understood, reflected in action standards for RJR's younger adult targeted products, and communicated with positive copy.

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YOUNGER ADULT SMOKERS: STRATEGIES AND OPPORTUNITIESINTRODUCTION

RJR's consistent policy is that smoking is a matter of free, informed, adult choice which the Company does not seek to influence. However, in order to plan our business, we must consider the effects those choices may have on the future of the Industry. Furthermore, if we are to compete effectively, we must recognize the imperative to know and meet the wants of those who are 18 and have already elected to smoke, as well as those of older smokers.

Purpose

This report is intended to provide additional learning on younger adult smokers (aged 18-24) to assist RJR in optimizing its strategic position with respect to this smoker group. While competitive issues, such as Philip Morris' continuing overdevelopment among 18-24 year olds, are a major focus of the analysis, the broader perspective is on the overall business opportunity which may be available to RJR through effective marketing to younger adult adult smokers.

There are five sections:

Section I. "The Importance of Younger Adult Smokers," explores the potential benefits/costs of "first brand" or switching strategies directed toward younger adult smokers, in comparison to smokers 25+. Key elements include the impact of 18-year-old smokers on the market, the effects of aging on both smoker share and market share, and the degree of potential switching opportunity. These analyses are based on share trends from MDD Tracker, loyalty rates from the 1983 Segment Description Study (SDS), NFO switching, and consumption patterns from Tracker and government studies.

Section II. "Successful 'First Brand' Strategies of the Past," uses never-before-available information from the 1983 SDS to trace the succession of key younger adult brands over the past 50 years. This allows an analysis of the key factors which may have been important to their growth and decline, as a potential framework for RJR's present/future younger adult smoker strategies.

Section III summarizes the "Key Learning" which can be concluded from Sections I and II on the importance of younger adult strength and the means which have successfully achieved that strength in the past.

Section IV gives "Implications and Recommendations for RJR" which were derived by applying this learning to today's younger adult smoker market.

Section V, "Key Trend Detail," amplifies key recommendations from Section IV.

Appendices support the main presentation as referenced in the text.

* "First Brand" strategies appeal to 18-year-old smokers rather than switchers ages 19-24.

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SECTION I

THE
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I. THE IMPORTANCE OF YOUNGER ADULT SMOKERS

Within five years, younger adults (18-24) will drop from 18% to 15% of the total adult population (18+). They will continue to decline in numbers until at least 1995, as the crest of the Baby Bubble pushes farther past age 25.

This shift in the population will cause smokers aged 18-24 to fall from 16% to 14% of all smokers by 1988. Even 13% would not be surprising, since smoking incidence has been declining more rapidly among younger adults than any other age group in recent years (see Appendix A).

Why, then, are younger adult smokers important to RJR?

1. VOLUME

Younger adult smokers are the only source of replacement smokers. Repeated government studies (Appendix B) have shown that:

- Less than one-third of smokers (31%) start after age 18.
- Only 5% of smokers start after age 24.

Thus, today's younger adult smoking behavior will largely determine the trend of industry volume over the next several decades. If younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle. In such an environment, a positive RJR sales trend would require disproportionate share gains and/or steep price increases (which could depress volume).

2. MARKET SHARE -- THE "FIRST BRAND" ADVANTAGE

A. ANNUAL GAINS FROM THE "NEW" MARKET

The 18-year-old smokers in the 1983 market were worth about 1.6 share of total smokers. By capturing half of these 18-year-old smokers, Marlboro gained .8 points of total smokers without needing to attract a single brand switcher. This gain was the equivalent of a successful two-style new brand introduction, with no cannibalization and no development/introductory costs.

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Furthermore, entering 18-year-old smokers account for all of Marlboro's strength among total 18-24. Loyalty rates from the 1983 SDS (i.e., the percentage of smokers who smoked Marlboro at age 18 and still do) show that Marlboro loses about 28% of its 18-year-olds by age 20 and another 14% by age 24 — a total loss of 42% over the six years between ages 18 and 24. Translating this to share points, Marlboro would be expected to lose .3 points of its .8 points of 18-year-olds before they reach age 24. This is, in fact, about the annual total NTO switching loss found for Marlboro in recent years. (See Appendix C.) But, since Marlboro gained .8 by becoming their "first brand" at age 18, it can afford the .3 switching loss and still come out .5 points ahead.

B. THE COMPETITIVE SQUEEZE

This steady influx of 18-year-old smokers causes the pre-existing smoker market to shrink in share values: smokers who were worth 100.0% of the market at the beginning of 1983 were worth only 98.4% by year end. Thus, a brand which had a 10.0% smoker share going into 1983 and did not attract any 18-year-old smokers would drop to 9.8% even if it kept every member of its franchise. This means that any brand/company which is underdeveloped among 18-year-olds must achieve net switching gains just to break even.

As a company, Philip Morris held more than 60% of these 18-year-old smokers in 1983 versus RJR's 15-20%, yielding PM a .5 point in-going SOM advantage in 1983 due only to "new" smokers. The power of this advantage can be seen by the fact that RJR's total competitive switching gains have been twice as large as PM's during 1980-83 yet, during the same period, RJR has lost smoker share while PM has made significant gains (See Appendix D). Furthermore, PM's younger adult smoker advantage has been increasing dramatically:

	SHARE OF SMOKERS 18-24					AVERAGE
	1979	1980	1981	1982	1983	ANNUAL CHANGE
RJR	26.1	25.0	24.3	23.5	21.3	- 1.2
PM	44.8	48.8	51.5	54.0	52.4	+ 3.4

Source: MDD Tracker

C. MOMENTUM FROM AGING

Once a brand becomes well-developed among younger adult smokers, aging and brand loyalty will eventually transmit that strength to older age brackets.

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C. MOMENTUM FROM AGING

An analysis of Tracker shares from 1979-83 (see Appendix E) shows that, apart from short term fluctuations:

- Incoming 18-year-old smokers and the movement of its existing franchise into older age brackets can explain all of Marlboro's smoker share gains in the past four years. Among smokers 25+, all of Marlboro's gains are attributable to this aging movement — switching appears to have had no net long term effect.

If Marlboro merely holds its share among younger adult smokers in the next five years, it is likely to gain at least 3 points of smoker share due to the aging movement of its present smokers (assuming its switching is no worse than in 1980-83). If Marlboro continues to gain share among younger adult smokers at its present rate, its overall smoker share could easily increase by a total of 5 points, from 19% in 1983 to 24% by 1988.

- Newport's growth can also be entirely explained by its younger adult strength and aging. Over the next five years, Newport is likely to gain .8 points of total smokers without any additional growth among younger adults. If its younger adult gains also continue, it could exceed a 4% total smoker share by 1988, a gain of about 1.5 points over 1983.

These examples demonstrate the momentum younger adult smokers give a brand. Although a competitor could slow this momentum by attracting switchers, the "first brand" would hold the high ground of brand loyalty in such a battle.

D. LONG-TERM DIVIDENDS — RATE PER DAY

Government and RJR studies spanning several decades have shown that smokers increase their consumption as they age. The chart below shows that smokers 25+ consumed 22% more than smokers 18-24 on average during 1980-82.

AGE	RATE PER DAY (1980-82 AVG.)		
	Cigts.	% Increase Vs. 18-24	Index vs. Total
18-24	26.2		85
25-34	30.6	+ 17%	99
35-49	34.1	+ 30%	110
50+	31.2	+ 19%	101
Total 25+	32.0	+ 22%	103
TOTAL	31.0	+ 18%	100

Source: Incidence/Rate Report, Year 1982.

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2. MARKET SHARE — THE "FIRST BRAND" ADVANTAGED. LONG-TERM DIVIDENDS — RATE PER DAY (Cont.)

Thus, the 18-year-olds who were worth 1.6 points of smoker share in 1983 were worth only 1.4 points of market share, since their consumption was below average (index of 85). However, by ages 35-49 they will be worth 1.8 points of SM — a 30% dividend on their original market share value. This consumption increase is the difference between having smokers 35-49 and having smokers who will age to 35-49.

E. EXTENDED BRAND LIFE CYCLE

The combination of brand loyalty, aging, and increasing usage tends to provide "life insurance" for brands which skew, or have skewed, younger adult.

For example, Marlboro relies heavily on 18-year-olds for its share growth. But if, from 1984 on, no 18-year-olds ever smoked Marlboro again, aging could let Marlboro almost hold its market share through 1990. The left side of the table below shows the contribution each age group makes to Marlboro's current smoker share and what that contribution would be in 1990 if Marlboro got no more 18-year-olds and merely moved its franchise smokers to older age brackets. On the right side of the table, the smoker share contributions are translated to market share, by factoring in rate per day differences. The bottom line shows that, even after seven years without 18 year-olds, aging could allow Marlboro's market share to hold within one point of its 1983 level.

	SMOKER SHARE CONTRIBUTION		MARKET SHARE CONTRIBUTION	
	1983 TRACKER	1990 PROJECTION	1983 EST.	1990 PROJECTION
18-24	6.8	0.0	6.6	0.0
25-34	6.5	6.8	6.8	7.2
35-49	3.8	7.9	4.6	9.6
50+	1.8	2.2	2.1	2.5
TOTAL	18.9	16.9	20.2	19.3

*Jan.-Dec., 1983 NSA.

Thus, even if a brand falls from favor among younger adult smokers, the younger adults it attracted in earlier years and their increasing consumption can carry the brand's market share for years, significantly extending its overall life cycle.

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3. SWITCHING OPPORTUNITY

Younger adults are more likely to switch brands than any other smoker group, i.e., they are a concentrated switching target. Their very high propensity to also switch styles within their brand suggests the latent potential for even higher rates of brand switching.

	PROBABILITY OF SWITCHING IN 6 MO.			
	BRAND FAMILY		STYLE IN BRAND	
	X	INDEX	Z	INDEX
18-24	16.6%	126	21.5%	178
25-34	13.4	102	12.8	106
35-49	12.1	92	10.4	86
50+	13.2	100	11.1	92
TOTAL	13.2	100	12.1	100

Source: NFO, 1981-1983 (first half).

Younger adult brand switchers (who then remain loyal) can also contribute the major portion of their aging benefits, including increased usage, to their second brand. Thus, switching by smokers 18-24 can yield a significant part, but not all, of the share advantages associated with a "first brand". Older switchers confer less, or none, of these benefits.

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THE IMPORTANCE OF YOUNGER ADULT SMOKERS**SUMMARY**

Though decreasing in number, younger adult smokers are a key marker for RJR because improved RJR performance among younger adult smokers could contribute more to long term profitability and positive share momentum than could be achieved from gains in any other age group.

1. Younger adult smokers are the only source of replacement smokers.

More than a share point of 18-year-old smokers enter the market every year. These offer a significant growth opportunity and also shrink the share value of smokers already in the market.

2. A "first brand" strategy has significant share advantages.

- Optimum ability to capitalize on the influx of 18-year-old smokers. This gave PM a .5 point in-going advantage over RJR in 1983.
- "First brands" compete from the high ground. They do not need switching gains to grow and can afford some switching losses. Brands which rely on older smokers must achieve net switching gains to break even on share.
- Strength among younger adult smokers will ultimately yield growth in older age brackets. Aging has been contributing all of Marlboro's and Newport's smoker share gains among smokers 25+.
- Aging of loyal younger adult smokers creates disproportionately large gains in market share, due to their increasing consumption. This does not accrue from gains among older smokers.
- Younger adult strength, past or present, will tend to extend the lifecycle of a brand.

3. Younger adult smokers offer the most concentrated switching opportunity.

- Smokers 18-24 are more likely to switch.
- Switchers aged 18-24 can provide more share advantage from aging/increasing consumption than switchers 25+.

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SECTION II

SUCCESSFUL
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II. SUCCESSFUL "FIRST BRAND" STRATEGIES OF THE PAST

In the 1983 Segment Description Study (SDS), smokers of all ages were asked what brand they smoked when they were 18 years old. By using these responses to represent the younger adult market of the past, the rise and fall of key younger adult brands over the last fifty years can be analyzed. By linking these brand trends in time to demographic/social/marketing changes, insights into the factors which affected those brands and might affect a younger adult brand today can be gained.

This section traces every brand which has risen to a 10% or higher share among 18-year-old smokers since the 1930's. There have been only six, but they include the major brands of the last half century — Pall Mall, WINSTON, Marlboro, Kool, SALEM, and Newport.

BACKGROUND

Although their rise cannot be traced, Lucky Strike, CAMEL, and Chesterfield were the giants of the cigarette market during the 1930's. Smokers who turned 18 in the 1930's seemed to favor Lucky Strike, but no brand skewed younger adult to the degree seen for the brands that would follow.

<u>1930's</u>	<u>AVG. SOM</u>	<u>18-YR-OLD SMOKERS</u>	
		<u>Share</u>	<u>SDI</u>
Lucky Strike	22%	32%	146
CAMEL	27	30	111
Chesterfield	27	29	74
All Other	24	18	75

PALL MALL: THE BRAND OF THE 1940'S AND 1950'S.

The key trend for Pall Mall was younger adult female smokers, who were rapidly becoming more likely to smoke at age 18. The SDS showed that females rose in importance from 30% of all 18-year-old smokers in the 1930's to 44% in the 1950's. This gain was large enough to create a 6% increase in the number of younger adult smokers between the 30's and 50's, even though there was a 15% decrease in the size of the younger adult population during that time.

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50192 8478

"Extra length" Pall Mall King entered the market in 1937. Initially, it had a prestige positioning, but was soon refocused to emphasize mildness and "easy" smoking. From the beginning, Pall Mall's development was about twice as high among younger adult females as males. This captured the rising trend of the younger adult smoker market and also made good strategic sense for ATC — Lucky Strike skewed male and Pall Mall skewed female. Thus, Pall Mall was in tune with the demographics of the times and its company's mix.

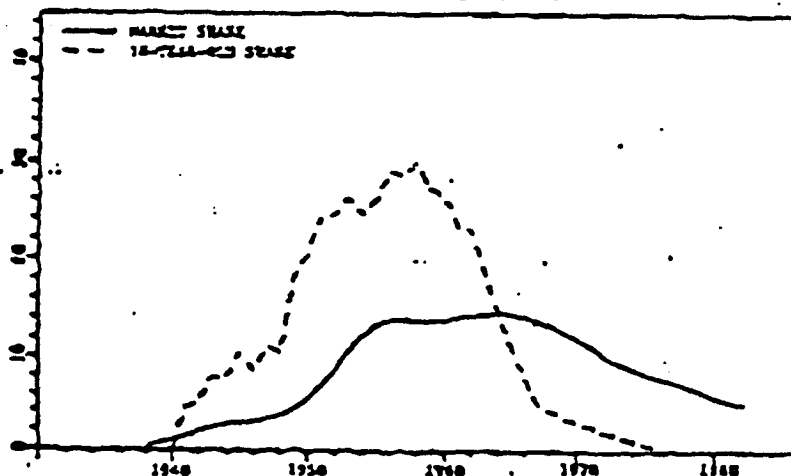


1956

During the 1940's, Pall Mall's share grew to 10% among all 18-year-old smokers, to 18% among younger adult female smokers, and was still rising. But since Pall Mall attracted fewer older smokers, its market share was only 3% after a decade (1947). By the 1950's, though, the aging payoff was inevitable: Pall Mall's SOM soared to 15%, with a younger adult smoker share twice that high.

PALL MALL

FIVE YEAR ROLLING AVERAGE SHARE



SOURCE: NIELSEN DATA AND LOGS INC.

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RJR000104

But, Pall Mall became out of step with its times when the cancer scares of the mid-1950's created the filter boom. Pall Mall might have defended itself with a filter line extension, but it didn't try until 1965, when it had few younger adult smokers left to defend.

After Pall Mall peaked, its younger adult franchise began to skew male. Younger adult female smokers -- the rising trend Pall Mall had captured -- moved on. But the brand loyalty and aging benefits of the younger adult smokers who remained with Pall Mall bolstered its market share for another 10 years.

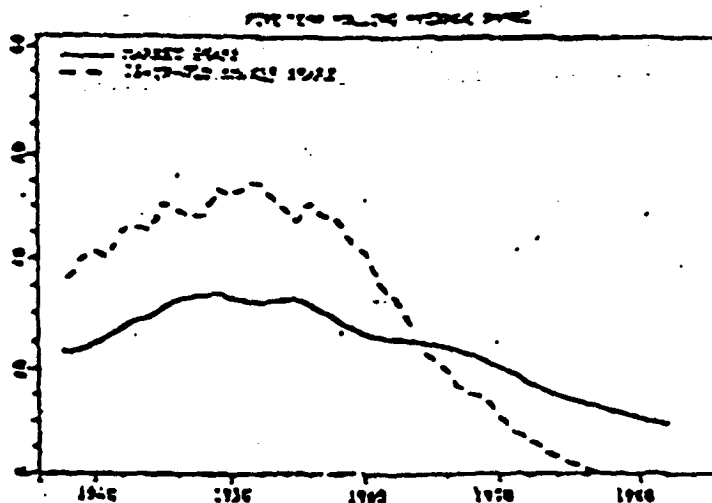
PALL MALL SHARE AMONG 18-YEAR-OLD SMOKERS

	1940's	1950-54	1955-59	1960-64	1965-74
Males	92	162	302	22	4
Females	18	40	30	13	2
TOTAL	10	26	30	19	3

Source: 1983 SDS

ATC's leading position among younger adult smokers, first with Lucky Strike and then Pall Mall, pushed it to #1 in the industry in 1940, when it passed RJR. However, since Pall Mall was ATC's last successful younger adult entry, the brand's downturn signalled the future performance of ATC as a company.

AMERICAN TOBACCO



Key Points About Pall Mall:

- Pall Mall's "extra length" was a product breakthrough in its day — one that promised extra mildness. It caught on right away with younger adult smokers.
- Pall Mall grew quickly among younger adult smokers because it was in tune with the 1940's, when the major trend in smoking was the rising importance of younger adult female smokers in the market.
- Pall Mall's younger adult strength was a long lead-indicator of its rapid market share growth in the early 1950's.
- Pall Mall's downturn among younger adult smokers was also a lead-indicator of the brand's eventual decline, although its market share held for another decade due to the loyalty and aging of the younger adult smokers it attracted in earlier years.
- Pall Mall became overdeveloped among males only during its decline.
- Since Pall Mall was ATC's first major younger adult brand, its downturn was a leading indicator of ATC's decline.

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RJR000106

WINSTON: THE HIT OF THE 1950'S AND 1960'S.

External influences in the 1950's contributed to the WINSTON opportunity.

1. The rising tide of health concern which peaked with the "cancer scare" of 1954.

Although "modern" filter cigarettes had been in the U.S. market since 1936, their market importance was almost nil until the early 1950's, when Viceroy sales quadrupled in less than two years. Reynolds, determined not to repeat its experience introducing CAVALIER against an already-too-well-entrenched Pall Mall, rushed WINSTON to market in March, 1954, near the crest of the health scare.

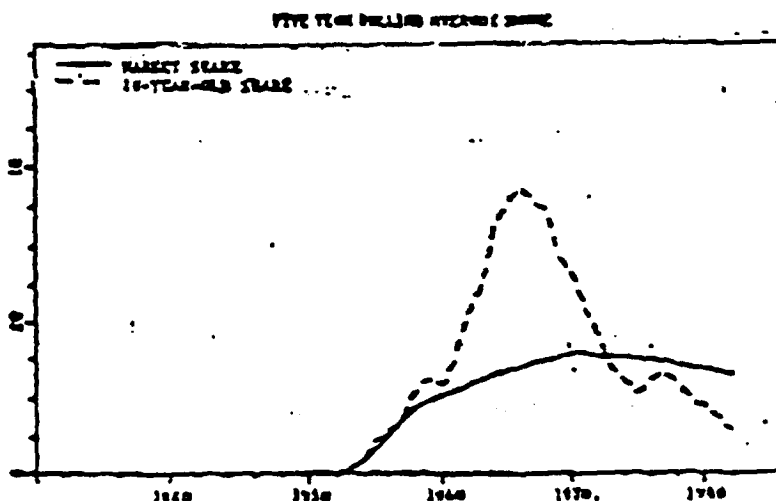
2. The spread of television.

WINSTON was introduced on TV — a "fad" that spread from 9% of all households in 1950 to 87% by 1960. Advertising dollars were a key advantage for WINSTON over its filter competitors, and the bulk of those dollars were used to leverage TV.

Younger adult and older smokers alike responded promptly to WINSTON's positive proposition — "WINSTON Tastes Good" — its point of difference from other filter brands and the product deficiency non-filter smokers might suspect. WINSTON let Kent and Viceroy sell the benefits of filters and, perhaps, make themselves look like "cissy brands" to younger adult smokers seeking maturity.

By 1958, WINSTON was the Number One filter brand and still showing steady market share gains. In the early 1960's, its share among 18-year-old smokers reached some 30%, twice as high as its market share: WINSTON's effect on SALEM and Marlboro during the early 1960's (as shown later) suggests that this 30% share was large enough to put peer pressure on WINSTON's side and make it a "bandwagon brand" among younger adult smokers.

WINSTON



WINSTON CIGARETTES

WINSTON suddenly lost favor with younger adult smokers in the mid-1960's. This was not due to any sudden changes in WINSTON or Marlboro ads or products. The ban on television advertising didn't hit until 1970. However, two major shifts in the 1960's environment may have left WINSTON less in touch with younger adult smokers.

1. The heavy antismoking activity in 1964-69 may have caused problems for WINSTON:

- WINSTON's positioning and its development were both slightly female, in tune with the younger adult smokers of the 1950's. However, the antismoking publicity in the 1960's had a disproportionate effect on younger adult females, so it changed the demographic mix. Within only a few years, females fell from 44% to 38% of younger adult smokers and, for a decade, the rising trend was male. Thus, WINSTON became out-of-tune demographically with the younger adult smoker market, because external influences had changed the market of the 1960's.
- The first FTC report, published in 1967, named WINSTON the highest "tar" non-menthol filter in the market — higher than some non-filter brands and 8 mg. higher than Marlboro. WINSTON's product-centered proposition may have been vulnerable on this front among younger adult smokers looking for mildness.
- The intense antismoking campaign on TV may have offset WINSTON's effectiveness in this key medium.

2. WINSTON's light-hearted approach may have also become less attuned to the changing younger adult mindset of the 1960's. In the era of Vietnam, campus riots, and the Chicago Seven, it seems likely that Marlboro's intense, unsmiling cowboy was a better fit.



1965



Come to where the flavor is.
Come to Marlboro Country

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50192 0403

The 1983 SDS showed that younger adult smokers are most likely to base their brand perceptions on the people they see using the brand — more than its advertising, package, or name. Thus, it is possible that WINSTON's own profile might have hastened its downturn among younger adult smokers. Whereas Pall Mall started with few older smokers, WINSTON started strong among all ages. Thus, by 1965, half of WINSTON smokers were over 35 and might have contributed to an older, "establishment" image for the brand.

As WINSTON lost its hold on the 18-year-old smoker market of the mid-1960's, its younger adult smokers dispersed to SALEM and Kool as well as to Marlboro. As with Pall Mall, WINSTON's younger adult female smokers moved more quickly, leaving WINSTON overdeveloped among younger adult males for the first time.

	WINSTON SHARE AMONG 18-YEAR-OLD SMOKERS				
	1956-60	1961-65	1966-70	1971-75	1976-80
Males	12%	31%	27%	16%	11%
Females	14	35	32	9	1
TOTAL	13 —→	32	29 ←—	13 ←—	5

Source: 1983 SDS

When the TV ban took effect in 1970, the TV anti-smoking campaign also ended and younger adult female smokers again became the rising trend. But by this time, Marlboro had become the "bandwagon brand".

There was an uptick in WINSTON's share among younger adult female smokers when its Lights 100's were introduced in 1977, well ahead of their Marlboro counterpart. But, overall, WINSTON's line extensions seem to have had no lasting effect on its younger adult smoker trend.

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Key Points About WINSTON:

- WINSTON benefitted from the health scares of the 1950's, which created the filter boom. It used a positive position — "WINSTON Tastes Good" — to capitalize on a negative environment.
- Favorable timing helped WINSTON. It attacked the filter market before earlier filter brands became entrenched.
- Younger adult smokers were as likely as older ones to be early WINSTON adopters.
- Younger adult strength was a leading indicator of WINSTON's extended market share gains and of its softening.
- Peer pressure — the "bandwagon effect" — seems to have worked for WINSTON in the early 1960's, when it had a 30% share of younger adult smokers.
- WINSTON may have lost popularity among younger adult smokers because changes in the external environment made WINSTON less in tune with both the demographics and the mindset of the 1960's than it had been in the 1950's. Its large number of older smokers may have contributed by linking the brand to the "establishment".
- WINSTON did not become overdeveloped among males until after its younger adult smoker share had begun to decline.
- WINSTON's line extensions do not appear to have had any long term effect on its younger adult smoker performance, although WINSTON Lights 100's may have caused a temporary rise until Marlboro responded.

P. 26

-16-

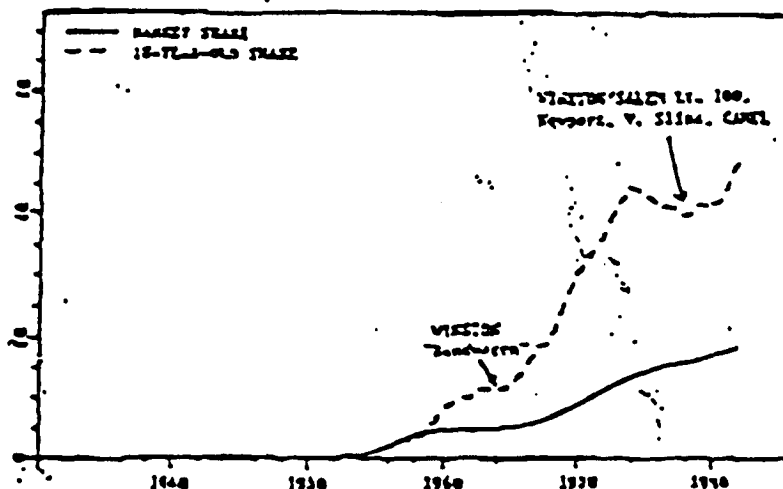
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MARLBORO

FIVE YEAR DOLLAR DOLLAR SHARE



MARKET SHARE 100% AND 1978 SHARE

Despite Marlboro's masculine positioning, it appears to have been a dual sex brand among younger adult smokers from the beginning. Marlboro skewed male to the same extent the total younger adult smoker market did, but was almost equally developed among younger adult males/females until after 1975.

Marlboro	SHARE AMONG 18-YEAR-OLD SMOKERS		
	Total	Development Index	
		Male	Female
1955-64	8.52	101	98
1965-74	31.8	104	94
1975-79	40.6	107	94
1979-83	50.3	116	84

Source: 1983 SDS

This balance was advantageous to the brand since the 1960's drop in female importance was only temporary. If Marlboro's masculine positioning had made it a heavily male brand, it would have positioned the brand on a long term declining trend.

After 1975, Marlboro not only started to skew male, it started to lose its grip on the 18-year-old smoker market:

- Marlboro's 18-year-old smoker share dipped in 1976-77 when both SALEM and WINSTON brought out Lights 100's styles and Marlboro failed to respond until 1978. This may partly account for Marlboro's increasing male skew in the late 1970's and, perhaps, for Marlboro Lights 100's switching gains versus WINSTON and SALEM in the 1980's.
- Newport began to nibble at Marlboro's "first brand" territory. Newport was a brand Marlboro was ill-equipped to compete against, because of its long-standing menthol weakness. This could be a reason for the strong emphasis on Marlboro Menthol in late 1982.
- CAMEL and Virginia Slims each took a bite.

These inroads on Marlboro's younger adult smoker stronghold in the late 1970's barely showed in the brand's market share because aging momentum from the 1950's and 1960's covered its tracks. But these may have been signals that Marlboro's masculine imagery was becoming less in-synch with younger adult smokers over time.

- Males were not the growth sector of the younger adult smoker market in the 1970's. Females were, rebounding from 38% importance in the 1960's to 49% of all 18-year-old smokers by the end of the 1970's.

	Z IMPORTANCE AMONG 18-YEAR-OLD SMOKERS			
	1950's	1960's	1970's	1980-83
Males	55 ———>	62 <————	53	51
Females	44 <————	38 ———>	47	49

Source: 1993 SDS

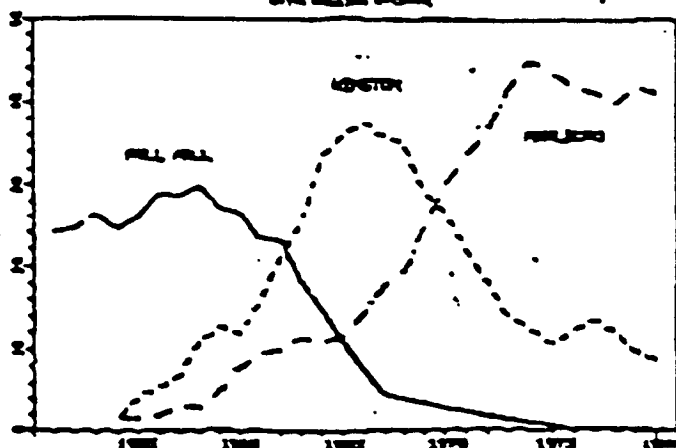
- In the 1983 SDS, younger adult males clearly still cared about being seen as masculine — they don't want feminine imagery! Marlboro's 18-24 smokers also want masculinity, because the majority of the brand's smokers are male. But, Marlboro's younger adult male smokers do not stress masculinity any more than other younger adult males. In fact, younger adult males who smoke other brands are somewhat more likely to want the rugged, traditional masculinity.

Thus, the evidence of share trend, demographics, and wants tends to suggest that Marlboro's positioning may have become less in tune with the younger adult smoker market during the late 1970's and 1980's.

Once Pall Mall and WINSTON had turned down among younger adult smokers, there was no return. Now, then, has Marlboro managed to hold, even recoup, among 18-year-old smokers in the 1980's?

1. In the 1983 SDS, younger adult smokers were much more likely than other smokers to base their brand perceptions on the people they see using the brand. But, among all brands, younger adults were most likely to base their Marlboro perceptions on brand users. (See Appendix F). Since, in 1983, 70% of Marlboro users were under 35 and fully 36% were under 25 (SDI = 218), Marlboro's very size among younger adult smokers may give it an effective positioning that has little to do with the positioning of its advertising. Marlboro's younger adult smokers can be their own campaign, automatically in tune with the times.
2. The SDS showed that Marlboro's key imagery was not masculinity, it was younger adult identity/belonging -- the brand for average younger adults, popular and acceptable among younger adult friends, not "too different". This makes sense as the imagery Marlboro's users would convey, apart from the brand's advertising, pack, or name.
3. Marlboro is clearly seen as a quality product, even by younger adult smokers who prefer other brands. Marlboro smokers want to "buy the best" and they think that Marlboro is the best. This may reflect specific product performance, since in-market test results over the last decade indicate that Marlboro King's smoother, less harsh delivery has been consistently preferred over the stronger WINSTON King. This was still the case among younger adult smokers in 1983 testing. (See Appendix G.)
4. Marlboro has the "bandwagon effect" still going for it. In fact, the trend over the decades has been for younger adult smokers to increasingly cluster behind one big "first brand", a trend that parallels the increasing pressures against smoking during these times. This could mean that as social pressures tend to isolate younger adult smokers from their nonsmoking peers, they have an increased need to identify with their smoking peers, to smoke the "belonging" brand.

SHARE AMONG YOUNGER ADULTS*

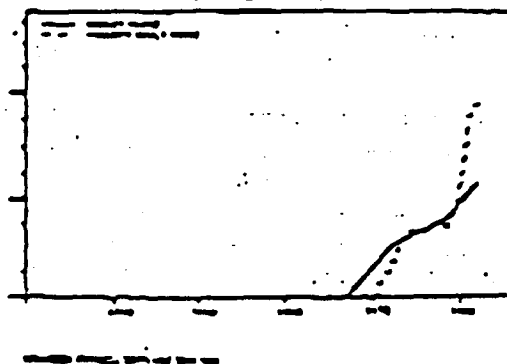


* 18-Year-Old Smokers, 1965-1985 Segment Description Study

Philip Morris may itself recognize Marlboro's vulnerability. (Certainly the brand's switching losses among 18-24 year olds have been visible in the 1980's, averaging the equivalent of .3 share points of total smokers every year.) While Marlboro could not be repositioned after 20 years of the same campaign, some clues suggest PM may be using other strategies to protect Marlboro's contribution to their younger adult share strength:

- Virginia Slims and Merit have been gaining disproportionate switching from Marlboro among smokers 18-24, allowing Philip Morris to keep 32% of Marlboro's net switching losses from 1980 to 1983 within the corporate fold — nearly twice PM's fair share. (See Appendix H). This suggests that Marlboro might serve PM as a "feeder brand", capturing 18-year-old smokers who can then be channeled to other PM brands.
- Virginia Slims' performance as an 18-year-old "first brand" has improved markedly in recent years. This may relate to its softer, more casual executions, which are more consistent with the younger adult Marlboro female's desire to not be "too bold".

VIRGINIA SLIMS



- The Merit repositioning seems to draw it closer to Marlboro, perhaps shortening the supply lines.

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Key Points About Marlboro

- 1960's
- Marlboro succeeded with a "first brand" strategy targeted to the leading edge of the Baby Boomer, who turned 18 in the 1960's.
 - Younger adult smokers have been a clear leading indicator of Marlboro's market share growth.
 - Marlboro was only a second entry in the taste/flavor filter market until it developed its image-intensive long term campaign/positioning. This took eight years of trial and error.
 - Marlboro's final positioning, set in 1962, was in tune with the mindset of the 1960's and also with the demographic shifts among younger adult smokers, since females dipped in importance during that decade.
 - Despite Marlboro's masculine positioning, it was almost equally developed among younger adult males and females until after 1975. Overdevelopment among males would have disadvantaged the brand.
- 1970-
- Marlboro's younger adult smoker share softened in the late 1970's, but it had built enough aging momentum that its 30M trend slowed only slightly.
 - Certain evidence suggests that Marlboro's positioning has become less in tune with younger adult smokers than it was in the 1960's.
 - Females, not males, have been the growing sector among younger adult smokers. Marlboro has been losing strength among females.
 - Younger adult Marlboro males' interest in masculine imagery is no stronger than the average younger adult male smoker.
 - Marlboro is a "bandwagon brand" today.
 - Marlboro users provide the brand's imagery today more than its advertising does.
 - Marlboro stands for "the average younger adult." Peer popularity is its added benefit.
 - Marlboro smokers believe in its high quality. It is seen as much smoother than WINSTON, but less strong.
 - Younger adult smokers' need for "belonging" is strong and may be increasing due to social pressures against smoking. Marlboro provides a means of belonging.
 - Marlboro suffers high switching between ages 18-24, but Philip Morris retains about twice its fair share of those switchers, via Virginia Slims and Merit.

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SALEM/Kool/Newport

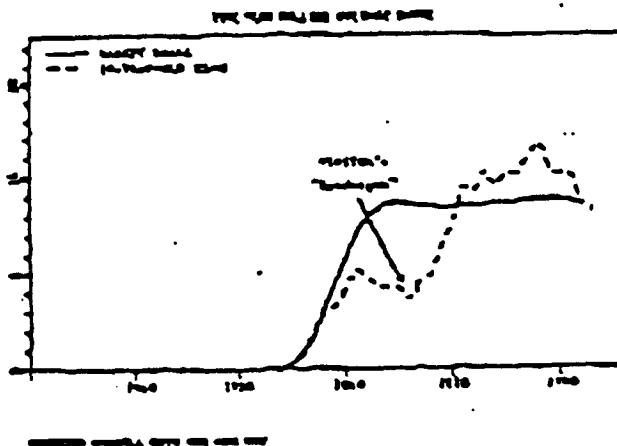
SALEM

SALEM's product breakthrough was "light menthol". Kool nonfilter had been in market since 1931, but it was advertised more like a cold remedy than a cigarette and, apparently, tasted like it. When SALEM lowered the menthol and added a filter, it cut an 8% niche in the market.

At first, younger adult smokers adopted SALEM as readily as older ones but, in the early 1960's, its 18-year-old smoker share went flat. It appears that this has more to do with WINSTON than either SALEM or Kool — the WINSTON "bandwagon effect" was drawing 18-year-old smokers like a magnet. When WINSTON let go in the late 1960's, SALEM could again attract its fair share of younger adult smokers.

Although SALEM became stronger among younger adult smokers of the 1970's, it has never become a true "first brand". A fair share of younger adult smokers, though, is enough to keep market share steady for a long time.

SALEM



Kool

The key trend for Kool was the emerging importance of younger adult Black smokers in the market. In the health-conscious 1960's, younger adult Blacks didn't back off from smoking to the extent that Whites did. Because of this, their importance surged from 6% of 18-year-old smokers in the 1950's to 10% in the 1960's.

Younger adult Blacks of the 1930's to 1950's had basically gone with whatever brand was big among younger adult White smokers (See Appendix 2). In the 1960's, they began to coalesce behind Kool, which only had a 2% share among younger adult Whites. It was time for Blacks to build their own brand in the 1960's, the heyday of Martin Luther King and "Black pride".

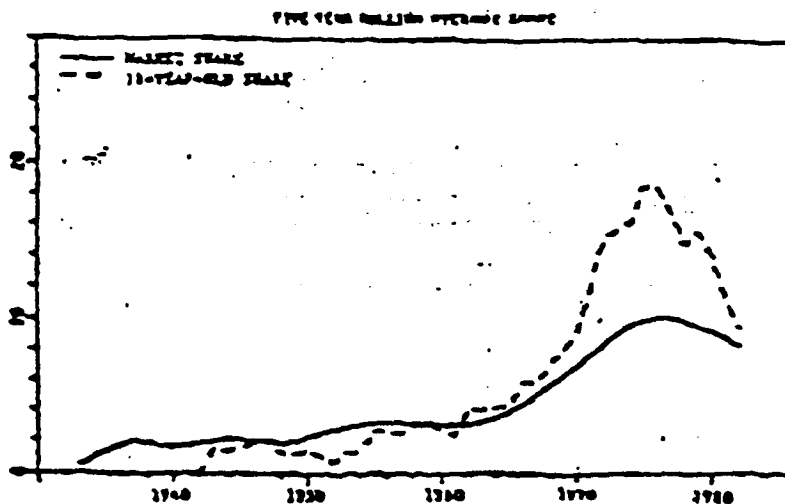
Kool apparently capitalized on this aspect of the 1960's by simply advertising to Blacks before its competitors did. Kool ads were in Ebony consistently from at least 1962, when our records start. This was easy for Kool, since its early-60's penguin campaign fit either race, and it was effective. Kool became "cool" and, by the early 1970's, had a 56% share among younger adult Blacks — it was the Black Marlboro.

	KOOL SHARE AMONG 18-YEAR-OLD SMOKERS					
	1950's	1960-64	1965-69	1970-74	1975-79	1979-83
Black	10%	12%	17%	56%	44%	34%
White	1	2	4	11	11	5
TOTAL	2	3	6	14	15	8

Source: 1983 SDS

Like Marlboro, Kool capitalized on the shifts in the 1960's market. And, by the 1970's, it was falling out of step with the trends of the times — younger adult Whites were returning to smoking, leaving Kool with a 500 BDI in a sector whose importance was no longer booming. Kool was in a bind in the Black market, too, with SALEM suddenly spending about as much as Kool against Blacks. (See Appendix J). Kool also splintered its positioning in the 1970's, advertising each line extension with its own thrust — Kool 100 was "Lady Be Cool", Kool Milds was dual sex, upscale, etc. Kool was vulnerable and Newport capitalized on that vulnerability.

KOOL



MARKET SHARE AND 18-YEAR-OLD SHARE

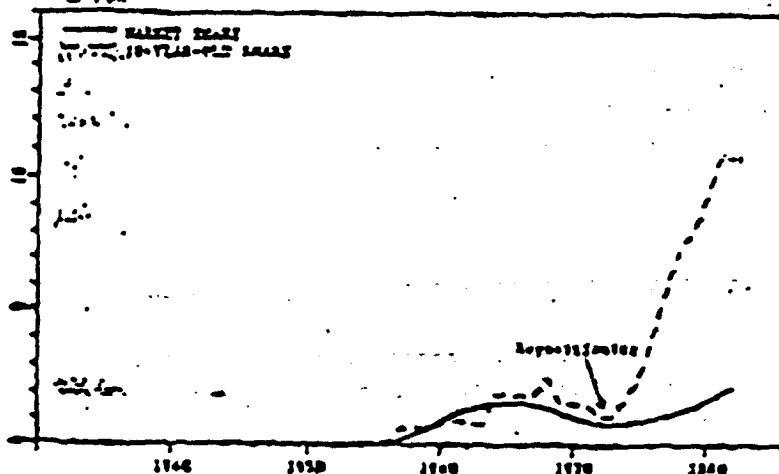
Newport

Newport was completely redone between 1970-73 — campaign, product, package. When the "new" Newport went to market in 1973, it went only against the northeastern U.S., which had been a focal point of Black population growth throughout the sixties as Blacks left the south.

Newport was the first menthol to emphasize imagery but, on the bottom line. Newport went after Kool with dollars. Newport's total ad spending in the mid-1970's was only about 30% of Kool's, but it was concentrated in some 20% of the U.S. Half of Newport's budget was in out-of-home. By 1978, Newport's regional spending against Blacks equalled Kool's national Black market spending. Newport had picked Kool's prime market, with a size it could afford, and essentially bought it. The results among younger adult smokers, especially younger adult Blacks, were immediate.

NEWPORT

THE NEW CIGARETTE SYSTEM



MARKET SHARE AND 10-YEAR-OLD SALES

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50192 8494

In the 1980's, Newport started rolling out across the South Atlantic, where migration patterns of the 1970's showed Blacks had been returning. Tracker data during this rollout period tend to confirm that Newport gained among younger adult Whites as it gained distribution, but its fundamental growth has been due to younger adult Blacks.

	NEWPORT MENTHOL SHARE OF SMOKERS				
	1980	1981	1st Half 1982	2nd Half 1982	1st Half 1983
<u>AGES 18-24</u>					
Black	18.6% →	22.4% →	25.2% →	28.9% →	36.6%
White	4.4	4.9	5.5	5.0	4.9
TOTAL	6.1 →	7.0 →	7.5	7.6 →	8.5

Source: MDD Tracker

All of Newport's growth has also been due to its King, which seems better attuned to younger adult product wants than Kool. In 1982, younger adult smokers rated both as acceptable products but found Newport King was significantly smoother, milder and less harsh than Kool King. (See Appendix K.) In qualitative work, Newport King is even described as a "light" (i.e., low "tar") product, despite its 18 mg. level.

The SDS showed that Newport, like Marlboro, relies heavily on its users to provide brand imagery among younger adult smokers (See Appendix F). And, Newport has the youngest franchise of any brand in the market -- 53% were 18-24 in 1983. Thus, it is no surprise that Newport has become the alternate younger adult identity brand, for those who don't want to just follow the crowd. For Blacks, it's today's alternative to Kool; for Whites, it's an alternative to Marlboro.

Key Points About SALEM/Kool/NewportSALEM

- In its early years, SALEM's appeal to younger adult smokers was overshadowed by WINSTON.
- SALEM gained among younger adult smokers of the 1970's, especially Blacks, by spending more effectively against Kool, but never has become a true "first brand".

Kool

- Kool's growth, much like Marlboro's, hinged on demographic shifts caused by the anti-smoking 1960's.
- Kool was in tune with the rising importance of younger adult Blacks in the 1960's. The mindset of "Black identity" made it time for Blacks to adopt their own brands, rather than follow the general market.
- Kool gained "Black identity" by advertising to Blacks before its competitors.
- When younger adult Whites returned to the market of the 1970's, Kool was suddenly too Black to fit the younger adult market and became vulnerable. Kool also splintered its heritage, positioning itself by style.

Newport

- Newport, when it was repositioned, essentially bought Kool's prime North Atlantic market by intense spending in out-of-home and against Blacks.
- It appears that Newport has gained younger adult White smokers by gaining distribution but its fundamental growth is among Blacks.
- Younger adult smokers rate Newport as milder/smoothier than Kool.
- Newport users are the main source of Newport perceptions. It is seen as the alternative younger adult brand -- for Blacks an alternative to Kool, for Whites an alternative to Marlboro. It's for those who don't want to follow the crowd.

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SECTION III

KEY
LEARNING

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RJR000122

III. KEY LEARNING: SUMMARY & CONCLUSIONS

The previous two sections have discussed the importance of a strong position in the younger adult smoker market and the strategies/circumstances which have, in the past, allowed brands/companies to achieve growth among younger adult smokers. By integrating the key points from these sections, several conclusions can be reached.

I. THE IMPORTANCE OF YOUNGER ADULT SMOKERS

- Strong performance among younger adult smokers is critical to generating sustained growth momentum for brands/companies.
 - "New" 18-year-old smokers represent about 1.4 share points of incremental volume each year.
 - A younger adult smoker who has been gained and retained appreciates in value over time because of increased consumption. Older smokers do not.
- The biggest cigarette brands of the last half century have derived their strength from high younger adult development — Pall Mall, WINSTON, Marlboro, and Kool. Newport may become another such brand, but its size is currently limited by distribution and lack of a broad geographical marketing effort.

In each case,

- Younger adult gains have been a long term leading indicator of the brand's market share gains. Typically, major market share growth has lagged the brand's younger adult smoker growth by at least five years.
- Continuing loss of younger adult strength has also been a leading indicator of market share softness and decline, although aging may bolster the brand's SOH for a decade or more.
- These brands have been the flagship brands driving their companies' performance and each has been superseded by a brand from another company. Thus, younger adult growth performance has been a leading indicator of long term corporate performance.

At present, Philip Morris and Lorillard are the only companies showing steady younger adult performance gains.

- Major performance gains among younger adult smokers do not necessarily have a major effect on short term total market share. This means that competition may be slow to notice an improvement of RJR performance among younger adult smokers and, therefore, may be slow to react.
- A "first brand" strategy (which necessarily targets younger adult smokers) provides an opportunity for unique long term benefits. However, it is likely that at least two to three years of close tracking would be required to determine the degree of success of a "first brand" effort.
- Younger adult smokers provide the most concentrated switching opportunity in the market. While a switching strategy is inherently less cost effective, it may be more feasible in the short term and may also produce more short term share results. Some switching appeal will be necessary to build enough early share for a "first brand" to hold the shelf.
- Younger adult smokers have been as likely or more likely than older smokers to be early adopters of brands which have ultimately succeeded as "first brands" over the last 50 years. Younger adults have not flocked to brands which were already large in the total market, possibly because the existing older franchise inhibits younger adult identification with the brand.
- Patterns observed for WINSTON suggest that a "bandwagon effect" may accrue to a "first brand" which achieves an 14-year-old share near the 30% level. When WINSTON's share reached this level, younger adult smoker growth was curtailed on both SALEM and Marlboro, until WINSTON's share again fell below that level.

II. SUCCESSFUL YOUNGER ADULT BRAND STRATEGIES OF THE PAST

The successful younger adult brands of the past have used strategies with many similar themes. In nearly every case, these brands have capitalized on the following types of opportunities, which will be discussed in more detail.

- A. External Factors
- B. Growth Sectors Within Younger Adult Smokers
- C. Out-of-Touch Competitors
- D. Product Delivery/Communication

A. External Factors

- Past periods of intense publicity on the health issue appear to have played a key role in the succession of the major younger adult "first brands."
 - WINSTON capitalized on the filter boom, which gained momentum from the "health scare" environment of the early 1950's.
 - Marlboro capitalized on the changing mix of males/females in the 1960's, which arose from their different reactions to the intense health publicity of that time.
 - Koal capitalized on the similar shift between Blacks/Whites in the 1960's.
- Based on the WINSTON experience, product "breakthroughs" which address external factors are more likely to produce short term share results than those based primarily on imagery wants of younger adult smokers.

B. Growth Sectors Within Younger Adult Smokers

Successful "first brands" have capitalized on subtle demographic shifts within the younger adult smoker market. Their "formula for success" appears to have been to target the FUTURE profile of younger adult smokers, i.e., to be better developed among sex/race/geographic groups which are gaining importance, but only to the extent that reflects the group's rate of growth. This "formula" will usually imply broad based, nearly balanced appeal rather than overemphasis on male/female, Black/White, or other factors.

- Pall Mall was strongly developed among younger adult female smokers while their importance was increasing most rapidly.
- WINSTON was introduced when younger adult female importance was modestly increasing and was slightly better developed among females, but essentially a balanced brand.
- Marlboro was slightly better developed among males during the 1960's, when female importance dipped, but was essentially a balanced brand until after 1975.
- Koal was highly developed among Blacks and grew when their importance among younger adult smokers surged in the 1960's.
- Newport targeted Blacks in the northeastern U.S., where the Black population was growing most rapidly in the 1970's, and has moved to the south, following the return migration.

B. Growth Sectors Within Younger Adult Smokers (Cont.)

- The dominant trend in the younger adult smoker market over the last 50 years has been the rising importance of females. Because of this, the major "first brands" have been overdeveloped among males only during their periods of decline. Marlboro has become overdeveloped among younger adult males only after 1975, when its share was softening among younger adult female smokers.
- One key to Marlboro's success in capturing the Baby Bubble appears to be that it attracted more 18-year-old smokers than WINSTON, within the younger adult smoker market. That is, it was clearly a "first brand", with relatively lower switching appeal.

C. Out-Of-Touch Competitors

In every case, the major younger adult brands have been succeeded by a competitor's brand positioned to be significantly different from the predecessor. The softening/decline of the major younger adult brands seems linked to an inability to "stay in tune with the times" as well as a new competitor "started in tune with the times" at its introduction/repositioning. While the real criteria for being "in tune" are probably the mesh between imagery and/or product and the wants of younger adult smokers of the times, demographics are a useful tool for identifying the likelihood of that mesh.

- Pall Mall became out of touch with younger adult smokers' product wants when it failed to effectively react to the filter boom of the 1950's. WINSTON fit those wants.
- WINSTON was the victim of subtle shifts which may have been transparent or seemed transitory at the time.
 - WINSTON's light-hearted campaign fit well with the mindset of the 1950's, but did not fit as well with the rising tide of intense younger adult rebels as Marlboro did in the 1960's.
 - WINSTON's campaign had a slightly female slant and so did its franchise. In the 1960's, younger adult females were losing importance and males were gaining — a better fit for Marlboro.
 - WINSTON's popularity among older smokers may have made it difficult to maintain an exclusively younger adult identity during the 1960's, when that want was most extreme.
- Kool found itself "too Black" in the 1970's as younger adult Whites were rapidly regaining market importance.

C. Out-Of-Touch Competitors (Cont.)

- Marlboro's advertising/positioning seems to have become less in touch with the demographic trends within younger adult smokers of the late 1970's and 1980's and, perhaps, their mindset.
 - Younger adult female smokers were the key growth sector in the 1970's and 1980's.
 - Today, Marlboro's younger adult male smokers do not have an above average interest in masculine imagery versus all younger adult males.
 - Philip Morris may have recognized Marlboro as vulnerable. Marlboro's disproportionate switching losses to Virginia Slims and Merit tend to feed Marlboro's losses back to PM. The campaign modifications on these brands may shorten the lines of supply.

D. Product Delivery/Communication

- Throughout the succession of "first brands", younger adult smokers have moved to "milder" products.
 - Pall Mall promised "mildness" based on its length.
 - WINSTON, as a filter product, would be seen as milder than nonfilters.
 - In the 1960's, Marlboro was "milder", i.e., significantly lower in tar, than WINSTON, as was advertised by the FTC. Today, Marlboro is still rated milder/smoothier than WINSTON by younger adult smokers and is preferred.
 - Kool and SALEM could be seen as milder because of their menthol.
 - Newport is perceived as milder/smoothier than Kool.
- Successful "first brands" have used positive product messages.
 - Pall Mall emphasized milder smoking "pleasure".
 - WINSTON "Tastes Good" despite its filter.
 - Marlboro is "where the flavor is", although historically and presently smoother than WINSTON.
 - Newport speaks to smoking "pleasure".

- By omission, no brand whose product messages remind the consumer of product negatives or portray the brand as a "weak cigarette" has succeeded as a younger adult first brand. For example, any brand which has specifically emphasized "low tar" (which implies remaining tar) has been limited to switching gains among maturing smokers.

SECTION IV

IMPLICATIONS
AND
RECOMMENDATIONS
FOR
RJR

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IV. IMPLICATIONS/RECOMMENDATIONS FOR RJR

1. Younger adult smokers are critical to RJR's long term performance and profitability. Therefore, RJR should make a substantial long term commitment of manpower and money dedicated to younger adult smoker programs. An unusually strong commitment from Executive Management will be necessary, since major volume payoffs may lag several years behind the implementation of a successful younger adult smoker strategy.

This time lag can also magnify the penalties for wrong turns in the development and implementation of younger adult smoker programs. To prevent such problems:

- RJR should develop objectives, planning procedures, and marketability criteria for younger adult brands/programs which reflect their unique, long term character. These may differ significantly from the approaches/measures which are appropriate to established brands or to new brands addressing older smokers.
 - Thoroughness should be emphasized.
 - Innovation, experimentation, and multiple approaches should be encouraged.
 - Rigorous, objective consumer-based action standards should be established to ensure that volume results will ultimately follow and that continuing Management commitment is warranted.
- RJR should make resources available to develop/improve its capabilities to thoroughly identify and track demographics, values/wants, media effectiveness, and brand performance within sectors of the younger adult smoker population. These tools will be critical to the development and implementation of effective programs among younger adult smokers.
- Because of the sensitivity of the younger adult smoker market, brand development/management should encompass all aspects of the marketing mix and maintain a long term, single-minded focus to all elements — product, advertising, name, packaging, media, promotion, and distribution. Tactics which could negatively affect the integrity of the strategy should be avoided.

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2. RJR should seek to better understand and capitalize on the market conditions/approaches which have successfully created younger adult strength for brands/companies in the past:

- A. External Factors
- B. Growth Sectors Among Younger Adult Smokers
- C. Out-Of-Touch Competitors
- D. Product Delivery/Communication

Since RJR's processes/tools have been better attuned to switching efforts than to "first brand" strategies, time and learning will clearly be required to fully assess the opportunities available through these avenues. It should be noted that the new/established brand program in the 1984 Plan already address the major issues/trends identified below, within the framework of current knowledge/processes. These Plans should continue as a basis for RJR's 1984 marketing efforts, but should be enhanced by a full-time dedication of resources to ensure a solution to the problem.

A. External Factors (Detail in Section V)

• SOCIAL ACCEPTABILITY

A breakthrough product which effectively addresses social acceptability concerns could revolutionize the market as WINSTON did in the health-concerned 1950's. The ultimate size of this opportunity will depend on younger adult smoker acceptance. Thus, RJR should consider:

- The need to develop a social acceptability product whose smoking benefits meet younger adult smokers' wants as well as other smokers' wants.
- Planning a second entry social acceptability brand which could emphasize reinforce younger adult imagery and product positives, thus avoiding the connotations of "social concern" which would likely be associated with the first entry. Thus, RJR could enter its own "Marlboro" to follow the "WINSTON of the 1980's."

• PRICING

Pricing is a key issue in the industry. Some evidence suggests that younger adult smokers are interested in price, but unlikely to adopt a brand whose only "hook" is price. To maximize the possible pricing opportunity among younger adult smokers, several alternatives should be considered:

- A price/value brand would need a conspicuous second "hook" to reduce possible conflict between younger adults' value wants and imagery wants. The most saleable "hooks" are likely to be based on product quality, since these provide easy-to-explain public reasons for switching. Suitable imagery should also be used.
- Since younger adult smokers with above-average interest in value are concentrated in the Coolness segment, it is possible that younger adult smokers might be responsive to an appropriately positioned value-oriented menthol entry.
- Tactically, extended periods of closely targeted pack promotion (BIGIF, sampling) in selected sites (e.g., convenience stores, military exchanges, special events) could lead to brand loyalty from repeated trial. This should be considered an investment program.

B. Growth Sectors Among Younger Adult Smokers (Detail in Section V.)

- Younger adult Hispanic and Black smokers should be key RJR targets, since they are gaining importance in the younger adult smoker market.
 - Resources/manpower should be made available to increase understanding of the dynamics, wants, and executional sensitivities within these markets.
 - Heavy-up advertising in selected media are likely to be beneficial against younger adult Black smokers, based on Newport/Kool history.
 - Competitive advantage could accrue from these special market programs, since Philip Morris has intensified its Black/Hispanic marketing efforts.
- Females are continuing to gain importance among younger adult smokers and, based on their diversity, should afford a number of potential opportunities.
 - Since the continuing trends to working women and "new masculinity" imply greater commonalities between the sexes, a dual sex brand which appeals to, but is not limited to women may be "in tune with the times."
 - "Style/Dress" remains a pronounced interest among younger adult female smokers, but should be executed to provide a clear point of difference and not be "too bold."

B. Growth Sectors Among Younger Adult Smokers (Cont.)

- "Moving up in the world" has been identified as a key enduring want among younger adult smokers. This imagery need is likely to grow, since younger adults who follow the Iasy Bubble are likely to experience limited opportunities for traditional success.
 - Limited opportunity to "move up" within the establishment may lead younger adults to seek entrepreneurial means of success, such as fame via the performing arts. This type of concept meshes with younger adults' key activities/interests, apparently represents an enduring want, and therefore may provide an innovative opportunity to be clearly different from competition.
 - A "status symbol" brand may attract some younger adult smokers, as an affordable compensation for other luxury items, if it can be executed to key on younger adult definitions of "class" and achieve clear difference versus competition.

C. Out-Of-Touch Competitors

- Based on history, RJR should emphasize competitive efforts which are clearly different from the target brands. Head-on or imitative strategies should be pursued as defensive rather than offensive measures. Thus, RJR should target younger adult smokers based on their inherent wants/differences rather than letting competitors define the market.
- Marlboro has become somewhat out-of-touch in that it is too male to fully capitalize on the female growth sector and its masculine imagery is less of a "hook" in the 1980's. However, Marlboro's users themselves provide the brand a strong positioning as an identity/belonging brand. Since Marlboro is not likely to be preemptable on belonging and is not strongly profiting from its "masculinity", other less head-on strategies hold more promise at present.
 - Marlboro smokers are half of the younger adult market and, thus, encompass a diversity of wants. This implies that successful attacks on any key sectors of the younger adult market are likely to hurt Marlboro. Thus, a variety of approaches should be developed to address the spectrum of younger adult smokers rather than limiting creative options by defining the market strictly in terms of Marlboro.

C. Out-Of-Touch Competitors (Cont.)

- Virginia Slims and Merit should be high priority competitive targets, since they appear to play a key role in defending Philip Morris against Marlboro's traditionally high switching losses.
- VANTAGE may have an opportunity to compete more effectively for younger adult Marlboro switchers, based on its history of switching gains from Marlboro. (Shown in Appendix II).

D. Product Delivery/Communication

- Smooth, mild product delivery seems to have been a key factor in the succession of younger adult brands. Therefore:
 - RJR should ensure that product wants among smokers 18-24 are fully understood and reflected clearly in action standards for products targeting younger adult smokers.
 - RJR should give high priority to eliminating elements of harshness from its younger-adult-targeted products.
 - RJR should use copy strategies which emphasize product positives to younger adult smokers. Connotations of "weak", "concerned", or "low tar" should be avoided and elements of mild, smooth, rich, smoking pleasure should be emphasized.

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SECTION V

KEY

TREND

DETAIL

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PRICINGOpportunity Analysis

Pricing is a key issue because of the pressures of the FET increase and the ensuing surge in sales of generic/private label brands. The impact of price on younger adult smokers is a complex question, which is likely to require additional learning, over time, to completely resolve.

Studies by the National Bureau of Economic Research (NBER) were used by the government as a rationale for the FET increase. These studies indicated that price had a much stronger effect on smoking by younger adults, particularly males, than on any other age group, because people were less likely to start smoking in an environment of higher cigarette prices. Thus, over an extended period of time, younger adult smokers would tend to become less price sensitive, since those who react most strongly would not become smokers. However, the NBER studies clearly imply that price influences younger adults, so that price/value may offer an opportunity for some share leverage among current younger adult smokers.

Strategic Alternatives

1. In the 1983 SDS, younger adult males were more likely than any other smokers to say they would buy generics for any price differential, large or small. Yet they were least likely of all smokers to report a generic usual brand. The explanation is probably conflicting wants:

- Younger adult males want to be seen as successful, someone who buys the best regardless of price.
- They want to make a good impression on others, smoke a brand acceptable to their friends.
- They have little interest in being seen as "smart shoppers".

Field reports from the military market confirm this conflict. Generic sales were booming but none of the men were seen smoking them -- because they were putting the generics in Marlboro packs.

Younger adult females have a more average attitude toward cost-conscious imagery but are also unlikely to adopt generics, perhaps because of conflict with their own "upward striving" wants, such as style/dress.

Thus, to maximize opportunity among younger adult smokers, a price/value brand will need a second "hook" to its proposition to allow younger adult smokers to switch on the basis of other, more acceptable wants as well as price. While imagery will be desirable, probably necessary, to brand success, the most likely second "hook" is product quality/taste since this is a more easily expressed public reason for adoption. Examples would be "computer technology produces better smoke at lower cost" or "pay for the best product, not the big brand name."

2. Younger adult males in the SDS were more likely than any other smokers to have taken advantage of B&W offers. Such pack promotions provide the savings benefit without conflicting imagery but typically yield trial or occasional usage rather than a change in brand loyalty. Carton offers, on the other hand, tend to reach older smokers. But, if B&W could closely target pack price promotions to younger adult smokers over an extended period of time, brand loyalty might be captured. This would be an investment program. Its cost effectiveness would depend on how tightly promotions could be targeted to younger adult smokers via, for example, military exchanges/canteens, selected convenience outlets, etc.

Any other price tactics on established brands could tend to undercut their perceived quality/value.

3. An SDS profile of younger adult smokers who have more interest than their peers in a value brand, but lower confidence in generics, showed high Coolness Segment development. Although, as seen above, price behavior may differ from expressed wants, there may be somewhat higher potential for a menthol entry to appeal to younger adult smokers on the basis of value/price.

Key Points

- Any price/value strategy will need a preemptive second "hook" to make it easy for younger adult smokers to switch for a reason other than price. Product-based "hooks" are easiest for consumers to publicly express.
- Since younger adult Coolness smokers have somewhat above average interest in value, a menthol entry may warrant consideration.
- Tactically, closely targeted, long running B&W's may yield some younger adult switching (as opposed to trial).

SOCIAL ACCEPTABILITY

Opportunity Analysis

Social pressures against smoking are high and increasing. This negative influence is somewhat similar to the health situation in the early 1950's. Therefore, it is possible that products which effectively address the perceived social negatives of smoking and also provide adequate smoker benefits could revolutionize the future market just as filters revolutionized the market during the 1950's. It is possible that RJR will have an opportunity to repeat the WINSTON success in the 1980's environment.

The long range impact of such products on the industry will ultimately depend on their acceptance among younger adult smokers, just as the filter revolution did. At present, younger adult smokers and nonsmokers are becoming polarized on social acceptability — younger adult smokers show less concern with the issue than older smokers, while younger adult nonsmokers are somewhat more concerned.

"In general, you are more acceptable to people if you don't smoke."

<u>Z AGREE</u>	<u>SMOKERS</u>	<u>NONSMOKERS</u>
18-24	49.52	73.2
25+	55.3	71.1
Total	54.4	71.5

Source: 1983 Smoking Attitudes Study

Given younger adult smokers' keen interest in peer acceptance/approval, it is likely that younger adult smokers would be interested in a brand which effectively addresses social acceptability and also provides the other smoking benefits they want. However, if that brand is positioned as "socially... concerned", younger adult smokers may try it as a novelty but are unlikely to adopt it as a regular brand — younger adults who wish to be seen as "concerned" are more likely to choose to be nonsmokers.

Strategic Alternatives

1. First Entry Brand

If RJR achieves first entry with a social acceptability brand, younger adult smokers are more likely to adopt it if the brand proposition is as positive and mainstream as possible. This was essentially WINSTON's approach to the health concerns in the 1950's. WINSTON let Kent and others call "safer" filters, while WINSTON let people know it had a filter but emphasized the positive of taste. For example:

- The added product benefit might be "enhances sociability" rather than courtesy (which implies potential disapproval from others).

- The name, package, and post-introductory advertising (once clear awareness of the point of difference was established) could emphasize supportable claims that the brand also provides a full measure of benefits of "old style filters" such as taste, satisfaction, draw, and imagery.

2. Second Entry Brand

The opportunity may be greater for a second entry social acceptability brand to establish mainstream appeal among younger adult smokers, since the first entry must push the product difference. Thus, the first entry might automatically be viewed as "concerned" even if it went mainstream post-introduction, i.e., quickly repositioned itself.

Other advantages of the second entry strategy could be:

- The strategy is equally viable whether RJR or another company hits market first with a social acceptability brand (assuming that product development timetables will be similar between companies).
- RJR could cover the bases by offering both a "concerned" and a younger-adult-oriented entry. If the first product is a satisfactory smoke, it could be used under both positionings.

3. Line Extensions

If social acceptability entries catch on, RJR should be prepared to defend its established brands with appropriate line extensions. Although a mainstream second entry brand could, itself, be a line extension, this would dilute leverage of "the new way to smoke" versus "old style filter cigarettes" and allow competitive brands to more easily respond. The least likely candidates for this type of line extension would be brands committed to "virility" such as CAMEL and, hopefully, Marlboro.

Key Points

- Products addressing social acceptability could revolutionize the market in the same way filters did in the "health scare" environment of the 1950's.

The long range outlook for such products will depend on their acceptance by younger adult smokers.

- To be adopted by younger adult smokers, a social acceptability brand should:
 1. Offer adequate smoking satisfaction as well as effective relief from social pressures.
 2. Be positioned positively rather than as "socially concerned", perhaps using essentially the WINSTON strategy of the 1950's.
- A second entry social acceptability brand is more likely to be able to position itself in the younger adult mainstream.

BLACK/HISPANIC YOUNGER ADULT SMOKERS

Opportunity Analysis

Younger adult Black and Hispanic smokers are dramatically increasing in importance and will, conservatively, comprise 20% of the 18-24 market by 1990.

	1965	1976	1980	PROJECTED 1990
BLACK				
X Pop. 18-24	11.2	12.4	13.0	14.8
X Smokers 18-24	12.9	13.4	13.6	14.5
Index	115	108	105	98
HISPANIC				
X Pop. 18-24	NA	5.7	7.5	9.9
X Smokers 18-24	NA	NA	3.9	5.1
Index	NA	NA	52	52
BLACK & HISPANIC				
X Pop. 18-24	NA	18.1	20.5	24.7
X Smokers 18-24	NA	NA	17.5	19.6

Sources: Census Bureau; Hispanic Omnibus Study; "Projections of Hispanic Population for the U.S., 1990 & 2000" (Center for Continuing Study of the California Economy); "Health, U.S., 1981".

BLACKS

Since the Koal phenomenon began in the 1960's, younger adult Blacks have moved increasingly to menthol products, which have accounted for 90% of the younger adult Black market in recent years. In 1983, 72% of Blacks 18-24 smoked one of the 3 major Coolness brands, although the segment has been getting some competition from Stylish brands. Virile brands, even Marlboro, have virtually no appeal to Blacks.

	SHARE AMONG BLACK SMOKERS 18-24				
	1980	1981	1982	1983	Avg. Pt. Chg.
Koal	34.6	30.3	27.9	21.8	- 4.3
Newport M	18.6	22.4	27.2	36.4	+ 5.9
SALEM	17.2	19.2	17.3	13.6	- 1.2
Coolness	71.3	72.8	73.0	72.1	+ .3
Menthol	68.7	69.9	71.5	68.9	+ .1

Source: MDD Tracker

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Newport is the growth brand among younger adult Blacks, yet it is not perceived as particularly relevant to their key wants/concerns: "moving up in the world," style/dress, and powerlessness. Effective spending appears to have been key to its success, although product mildness versus Kool may have played a role.

Kool appears to have risen partly from an emerging desire for Black identity, but it is not clear that this want is as pronounced among younger adult Blacks today.

- The SDS showed that younger adult Blacks were less likely than older Blacks to believe "it is important to remember my roots."
- Although Newport is prominently advertised in Black publications and spends about 16% of its brand dollars against Blacks, 59% of its dollars go to OOH which is primarily general market.
- In qualitative work, younger adult Blacks feel limited rapport with today's Black "leaders", e.g., Jesse Jackson.

Thus, Coolness strength among younger adult Blacks may continue to decline in the future in favor of Stylish brands which key on Black wants but also have appeal in the general market.

Hispanics

The Hispanic market is very difficult to address because:

- Mexicans, Cubans, and Puerto Ricans form three distinct segments which differ in wants, lifestyles, even language.
- Many Hispanics insist that advertising be in the Spanish language and that visual executions be perfectly attuned to their lifestyles, self image, and traditions. Hispanics are extremely literal.
- Illegal entry makes even population data difficult to obtain and tools for understanding/tracking the Hispanic market have been quite primitive compared to general market capabilities.

Mexicans are the largest and fastest growing sector of the Hispanic population and also the sector in which RJR's performance is strongest.

Percent of U.S. Hispanic Population

	<u>1980</u>		<u>2000</u>
Mexican	61%	→	64%
Puerto Rican	14		12
Cuban	7		5
Other	18		19

Source: Center for Continuing Study of the California Economy.

Marlboro is the leading brand among Puerto Ricans and Cubans and recently appears to have intensified its efforts against the Mexican sector. In fact, Philip Morris appears to be increasing special market spending behind all of its key brands, with special Hispanic campaigns recently appearing for Marlboro, B&W, and Players. (See Appendix L.)

Key Points

- Blacks/Hispanics will comprise 20% of all younger adult smokers by 1990.
- Younger adult Black smokers appear to be highly responsive to effective advertising spending. They appear somewhat more likely to be attracted to a brand which keys on their interests in "moving up" and style/dress and can achieve reasonable development in the younger adult general market.
- Knowledge of the younger adult Hispanic market is extremely limited, although it is fairly clear that Mexicans are the key sector. Success among younger adult Hispanics is likely to require development of an adequate information base and extreme sensitivity to executional elements.
- Philip Morris has placed much heavier emphasis on ethnic spending in recent years and evolved on-going Hispanic campaigns for Marlboro and Benson & Hedges.

YOUNGER ADULT FEMALE SMOKERS

Opportunity Analysis

Younger adult female smokers have been a driving force behind industry growth during the last half century as they have become more likely to smoke at age 18 and, over time, spread in importance within older age brackets.

% IMPORTANCE AMONG 18-YEAR-OLD SMOKERS

	<u>1960's</u>	<u>1970's</u>	<u>1980-83</u>
Males	62	53	51
Females	38	47	49

Source: 1983 SDS

Younger adult females are continuing to gain importance among younger adult smokers, due to their stronger incidence trend versus younger adult males. Based on government reports in recent years expressing alarm at increased smoking among teenage girls, younger adult females are likely to continue to slowly gain importance, although external factors such as social acceptability and price may affect the outlook.

INCIDENCE AMONG YOUNGER ADULTS 18-24

	<u>TOTAL</u>	<u>MALES</u>		<u>FEMALES</u>	
	<u>Z</u>	<u>Z</u>	<u>INDEX</u>	<u>Z</u>	<u>INDEX</u>
1980	32.7	33.7	103	31.7	97
1981	31.7	31.6	100	31.8	100
1982	29.4	28.8	98	30.1	102
1983	29.0	28.8	99	29.3	101

Source: MDD Tracker

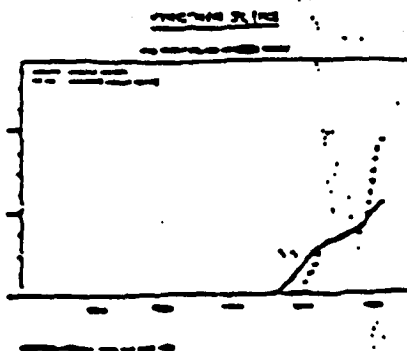
Key differences in wants between younger adult female smokers and other smokers were identified in the 1983 SDS.

KEY WANTS/CONCERNS OF FEMALES 18-24

	<u>VS. TOTAL SMOKERS</u>	<u>VS. TOTAL 18-24</u>
Belonging/Fitting In	+	-
Moving Up in World	+++	No Difference
Powerlessness	++	++
Style/Dress	+++	+++
Savings/Value	++	+++
Health/"Tar"	+	+++
New Male/Female Roles	+++	+++
Social Acceptability	+	+++
Smoking Problems	+	++

Despite key differences in tastes from younger adult males, younger adult females tend to smoke dual sex brands rather than specifically targeted female brands, e.g., 34% smoke Marlboro versus 11% for Virginia Slims.

- Virginia Slims was introduced in 1968 but appears to have gained appeal as a younger adult female "first brand" only in recent years.



This may relate to its gradual campaign evolution from heavy makeup and avant garde fashions to more friendly, casual imagery. This transition may have been speeded by the introduction of SALEM Slim Lights, which outperformed all other competitors in attracting switchers from Virginia Slims.

VIRGINIA SLIMS SWITCHING AMONG FEMALE SMOKERS 18-24

	NET GAINS		NET LOSSES	
	PTS.	%	PTS.	%
SALEM	-	-	-0.14	45
Barclay	-	-	-0.05	16
CAMEL	-	-	-0.02	6
VANTAGE	-	-	-0.02	6
36H	-	-	-0.02	6
Generic	-	-	-0.02	6
Marlboro	+0.26	39	-	-
Merit	+0.12	18	-	-
Newport	+0.05	8	-	-
Kent	+0.05	8	-	-
Parliament	+0.05	8	-	-
All Other	+0.13	20	-0.04	13
	+0.66	100%	-0.31	100%

Source: NFO, 1980-83 (1st Half) Avg. Per 6 Mo.

- Although base sizes are small, there is some indication that Virginia Slims younger adult core females are true Stylish segment smokers who desire to make a bold statement with their brand, whereas Virginia Slims fringe smokers consider the brand to be nearly too bold for their tastes. Its key imagery is, naturally enough, "today's woman".

Virginia Slims weakness may be that it fits not only a particular type of female but a particular stage of life. The prototypical younger adult female Virginia Slims smoker is like its overall franchise — she is from a family with income over \$25K (BDI = 160), has some college education (BDI = 130), is employed as a secretary/clerk (BDI = 160), and is single or newly married. The drop in Virginia Slims development among married/formerly married women suggests that Virginia Slims somehow does not fit the married woman's lifestyle and thus, has limited opportunity as a lifetime brand.

VIRGINIA SLIMS DEVELOPMENT

	<u>TOTAL FEMALES</u>	<u>18-24 FEMALES</u>
Never Married	213	126
Married < 2 Years	182	96
Married 2+ Years	77	77
Formerly Married	77	48
Total BDI	100	100
Share	6.0%	10.7%

Sources: 1983 SDS, 1983 Tracker

- Most younger adult females smoke a dual sex brand — not too masculine (e.g. CAMEL), but not strictly female (Virginia Slims). While specially targeted female brands will undoubtedly play a role in the future market, lifestyle trends suggest that commonalities between younger adult males/females are increasing over time, so that dual sex waxes are likely to remain prevalent.

- Younger adult females are increasingly moving into the workplace, at a more rapid pace than older women.

LABOR FORCE PARTICIPATION (2) AGES 20-24

	<u>1960</u>	<u>1970</u>	<u>1975</u>	<u>1981</u>
Females 20-24	46.1	57.7	64.1	69.6
Index vs. Total Females	122	127	133	134

- Younger adult females have become as likely as males to attend college.

2 COLLEGE ENROLLEES 18-24

	<u>1960</u>	<u>1970</u>	<u>1975</u>	<u>1981</u>
Males	63%	57%	53%	50%
Females	37	43	47	50

- Females are increasingly opting to remain single during their younger adult years and to live alone.

<u>Ages 20-24</u>	<u>% WHO HAVE NEVER MARRIED</u>			
	<u>1960</u>	<u>1970</u>	<u>1975</u>	<u>1981</u>
Males	53.1	54.7	59.9	→ 69.5
Females	28.4	→ 35.8	→ 40.3	→ 51.9

	<u>YOUNGER ADULT FEMALES LIVING ALONE</u>			
	<u>1960</u>	<u>1970</u>	<u>1975</u>	<u>1981</u>
Number (M)	110	282	501	752

Source: Statistical Abstracts, 1982-83, pages 41 & 44

- Both younger adult males and females are more likely to say they "associate with the new ideas of men/women" than their older counterparts.

These increasing lifestyle commonalities suggest that females will continue to be more attracted to dual sex brands which adequately address their wants than to highly targeted female-only brands.

Key Points

- Younger adult female smokers have greatly increased in importance over the last 20 years and are likely to continue to slowly gain in importance, unless external factors intervene.
- Virginia Slims... or similar female-only brands, are likely to hold a niche in the future younger adult female market, but essentially dual sex brands which are attentive to female wants/concerns are likely to provide the larger opportunity.
- Style/dress remains a pronounced interest among younger adult females, but should be executed to provide a clear point of difference and not be "too bold".

51601 8452

50192 0521

"MOVING UP IN THE WORLD"

"Moving up in the world" is a key want among all groups of younger adult smokers and the one which most distinguishes them from older smokers in the SDS. This is not surprising, given that they are in the process of developing their education and/or career and establishing their independence (which requires dollars).

Dollars may well be the key measure of success to younger adult smokers, since the desire to move up decreases as their incomes increase. Blue collar workers (who are the highest earning younger adults) are less upward striving than average. Education makes no difference.

Younger adult smokers are more likely than older to emphasize the "image" of success. They like to know important people and feel "there's nothing wrong with showing you've made it," regardless of race or sex.

Over the next 10 years, younger adults' desire to "move up" may become more frustrating, since the peak of the Baby Bubble will ride just ahead of them, clogging the traditional avenues of advancement and success. This suggests that they may move to alternate paths as other "powerless" minorities have done in the past.

- Some may compensate by seeking to acquire affordable status symbols, possibly a prestige/class cigarette brand. However, it is not entirely clear that the younger adult definition of "class" will entirely mesh with the status symbols prized by the older establishment, since they seem to prefer designer jeans to couturier originals and flair/individuality above elegance. BM, the only established "prestige" brand has attracted some interest among younger adult Blacks/Hispanics but is underdeveloped among younger adult smokers as a whole.
- One option successfully used by entrepreneurial minorities in the past is to seek fame by exercising special talents in the public eye — women achieved visible success through the stage or screen (or by marriage), Blacks moved up through sports and music, Jews became famous on the comedy circuits, "poor boys" from Liverpool or Mississippi made it with rock and roll.

The desire to fame, the fantasy of "being discovered", and "star worship" appear to have been common among younger adults for generations in varying forms. Today's younger adults appear to be no exception:

- In qualitative work, when younger adult smokers are asked to name their heroes, they tend to name performers rather than the sports figures (e.g., Jo DiMaggio) or political leaders (John Kennedy, Martin Luther King) who may have had more attention in the past.
- The "Newsstand Weeklies" (People, National Enquirer, etc.) which key on performers, are the most-read periodicals among younger adult smokers (See Appendix M).

- The TV series "Fame" appealed to younger adults and is returning via syndication.

Music is probably the most popular mode of performance among younger adult smokers:

- A special cable network, MTV, offers nothing but video renditions of popular younger adult music.
- Younger adult smokers in the SDS were twice as likely to actively participate in musical activities (i.e., actually play or sing) as smokers 25+ were.
- Younger adults tend to associate Marlboro with the occupation of musician. This was mentioned by 21% of smokers 18-24 rating Marlboro versus 14% of all smokers, the most pronounced difference found between older/younger adult responses. This is unusual, since Marlboro's only formal association with music has been some recent special events sponsorship. This suggests that these younger adult male Marlboro users may be characterizing themselves as they are or wish to be.

Although "fame" is a concept rather than an opportunity at present, it would represent an innovative point of difference from any past/present brand and appears to be relevant to younger adult wants/interests.

Key Points

- "Moving up in the world" is a key, enduring want among younger adult smokers and is likely to become of even higher importance as avenues for traditional success are increasingly blocked by the Baby Bubble.
- Younger adults tend to emphasize the image of success rather than "self improvement".
- A "status symbol" brand may attract some younger adult smokers, as an affordable compensation for other luxury items, if it can be executed to key on younger adult definitions of "class" and achieve clear difference versus competition.
- Limited opportunity to "move up" within the establishment may lead younger adults to more entrepreneurial means of success, such as fame via the performing arts, especially music. This meshes with younger adults' key activities/interests and apparently represents an enduring want applicable to both sexes and races. Therefore it may provide an innovative new brand/repositioning opportunity, clearly different from competition.

APPENDICES

50152 0524

51601 8455

RJR000149

NUMERICAL IMPORTANCE OF YOUNGER ADULT SMOKERS

<u>Ages 18-24:</u>	<u>1975</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
% of Total Pop. 18+	18.8%	18.3%	18.3%	17.9%	17.5%
Incidence of Smoking Smoker % of 18-24 Pop.	36.0%	32.7%	31.7%	29.4%	29.0% (P)
Index vs. Total 18+	106	99	98	95	94 (P)
% of Smokers 18+	20.0%	18.3%	17.9%	16.9%	16.4% (P)

(P) = Preliminary Tracker Data

Sources: Incidence and Rate Report, Year 1982, MDD Tracker, and Census Bureau population estimates.

<u>Ages 18-24 in 1988:</u>	<u>High Side (1)</u>	<u>Low Side (2)</u>
% of Total Pop. 18+	14.9%	14.9%
Incidence of Smoking: Index vs. Total 18+	94	87
% of Smokers 18+	14.0%	13.0%

(1) High Side assumes younger adult incidence follows the same trend as the total population (18+).

(2) Low Side assumes younger adult incidence falls more rapidly than among total smokers, to the average degree seen from 1975 to 1983.

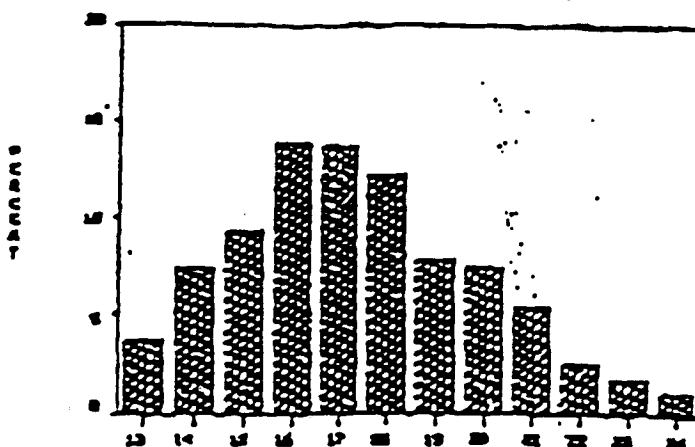
51601 8456

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RJR000150

YOUNGER ADULTS' IMPORTANCE AS REPLACEMENT SMOKERS

1 ONLY MALE SMOKERS BY STARTING AGE



More than two-thirds of male smokers start by age 18. Only 5% start after age 24.

Current Male Smokers by Starting Age

Cumulative %

	<u>Start By Age</u>	<u>Start After Age</u>	
12	9.92	90.12	
13	13.4	86.6	
14	20.8	79.2	
15	30.3	69.7	
16	42.9	57.1	
17	53.6	46.4	Median = 16.7 years
18	68.7	31.3	
19-20	84.0	16.0	
21-24	94.6	5.4	
25+	100.02		

Sources: Average of HEW data reported in Adult Use of Tobacco, 1970 and 1975.

Although women of the early 1900's started to smoke at later ages than men, there has been little difference in recent decades.

<u>Year of Birth</u>	<u>Median Starting Age of Female Smokers</u>
1900-1920	20.0 years
1920's	18.5
1930's	17.7
1940's	17.1

Source: HEW, Changes in Cigarette Smoking Habits, 1955-66.

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RJR000151

MARLBORO SWITCHING LOSSES — ACTUAL VS. PREDICTED

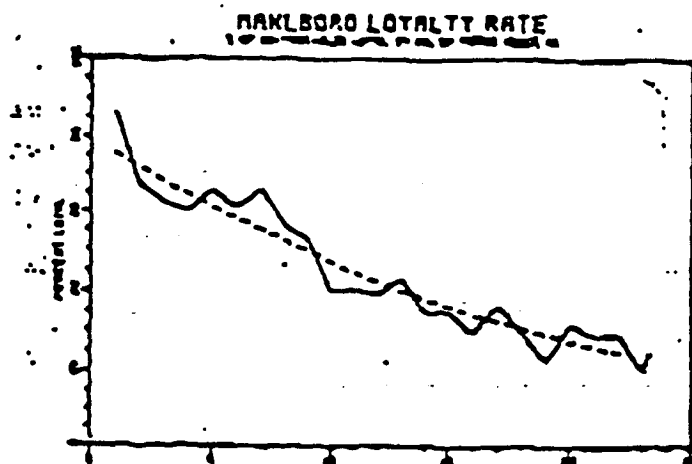
• NFO: Avg. 1980 — First Half 1983

<u>Age</u>	<u>Importance Of Age To Total Smokers *</u>	<u>Avg. Annual Gross Switching Loss **</u>		
		<u>Pts in Age</u>	<u>Wtd Pts Of Total</u>	<u>% Of Total</u>
18-24	17.2X	-1.46	- .25	39%
25-34	25.8	-.64	-.17	27
35-49	27.6	-.40	-.11	17
50+	29.4	-.36	-.11	17
TOTAL	100.0X	-.64	-.64	100%

* Source: MDD Incidence/Rate Report, Year 1982; MDD Tracker, 1st Half, 1983.

** NFO gross switching losses within age converted to total and points of total by importance weights above.

• Predicted By SDS Loyalty Rates



• Marlboro 18-Year-Olds
After —

	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>Average</u>
	<u>Yrs</u>	<u>Yrs</u>	<u>Yrs</u>	<u>Yrs</u>	<u>Yrs</u>	<u>Yrs</u>	<u>Yrs</u>	
• 2 Remaining Loyal	100%	76%	72%	68%	65%	61%	58%	71%

Since 71% remain loyal, 39% must switch over the six years, i.e., an average of 6.5% per year among the average 71% of the original group who remain. $71\% \times 6.5\% = 4.6\%$ average annual switching loss.

<u>Marlboro</u>	<u>Average 1980-83 (1st Half)</u>
Tracker Share Among 18-24	35.3%
Avg. Importance of 18-24	$\times 17.2\%$
Value in Points of Total Smokers	6.1%
Average Annual Switching Loss	$\times -4.6\%$
	- .25 Points

RJR000152

51601 8458

50192 0527

RJR/PM SWITCHING VS. SMOKER SHARE PERFORMANCE

	POINTS OF TOTAL SMOKERS			
	NET SWITCHING		SHARE	
	RJR	PM	RJR	PM
1980	+ .26	+ .45	33.3	29.2
1981	+ .27	- .25	32.1	31.0
1982	+ .42	+ .24	32.8	32.3
1983 (1st Half)	+1.00E	+ .36E	33.0	34.2
Avg. Change Per 6 Mo.	+ .41	← + .18	- .1	→ 1.0

Sources: NFO and MDD Tracker

51601 8459

50192 0520

RJR 000153

RJR Sales Company
3357 Carlemon Lane
Sarasota, Florida 34232

J.P. McMahon
Division Manager

RJR

January 10, 1990

TO: Sales Reps
SUBJECT: Young Adult Market

VERY IMPORTANT, PLEASE READ CAREFULLY!!!

Dear All:

The following information is needed back in this office no later than January 22. I need all of you to study the attached scroll list of monthly accounts in your assignment that are presently doing more than 100 CPW for purposes of denoting stores that are heavily frequented by young adult shoppers. These stores can be in close proximity to colleges high schools or areas where there are a large number of young adults frequent the store.

The purpose of this exercise, is to be able to identify those stores during 1990 where we would try to keep premium items in stores at all times. I might add, these stores may or may not have Preferred Presence units. I realize that you do not have enough time between now and January 22nd to visit all stores in your assignment, but by now I would think you would have a good feeling on this subject. Should you absolutely need more time to identify any particular convenience store, please advise upon receipt of this letter. I am asking you to return this list highlighting those stores that you are classifying as young adult.

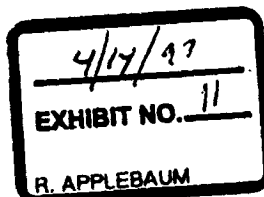
Thanking you in advance on this subject.

Sincerely,


J. P. McMahon

JPM/tge

Enclosure



RJR 000030

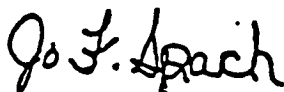
51601 8460

Principal
Page Two
January 11, 1990

answers to the many unanswered controversies surrounding smoking and the fundamental causes of the diseases often statistically associated with smoking -- we believe can only be determined through much more scientific research. Our company intends, therefore, to continue to support such research in a continuing search for answers.

We would appreciate your passing this information along to your students. You may also be interested in the enclosed publications presenting the position of our company and the tobacco industry on the issue of youth smoking.

Sincerely,



(Mrs.) Jo F. Spach
Manager, Public Information
Public Relations Department

JFS/jmd

Enclosures

51601 8461

J. P. McMahon
Division Manager

PERSONAL & CONFIDENTIAL

May 3, 1990

TO: All Sales Reps

IMPORTANT - PLEASE READ CAREFULLY!

Dear Ladies & Gentlemen:

In reviewing my files, I have noticed that I sent you a letter dated January 10th of this year, asking you to identify stores located in close proximity to high school and colleges for placement of our premium items. First of all, looking back on this letter, I realize I was wrong in identifying the specific age group of these young adults. It has always been this company's policy that we do not promote or sell our cigarette products to anyone under the age of 21.

To clarify this letter of January 10, it was not my intention to recruit or promote smoking with high school or college aged students. I have never asked you to do anything different in gaining sales with this age group, but again I must say I was wrong with my reference to "high school aged" young adults, and I deeply regret and apologize to you for this reference.

In talking to most of you over the past three weeks, you have told me that you are not placing any special emphasis in stores located close to schools or colleges or that we are not promoting smoking, or even making consumer offers to anyone under the age of 21.

We will continue to work our pack promotions with special emphasis in higher volume C-stores, but we will not place additional emphasis, or additional premium items in any store where there is a large concentration of under 21 aged shoppers. Again, I must add, it is not my intention nor was it ever to persuade young people to smoke.

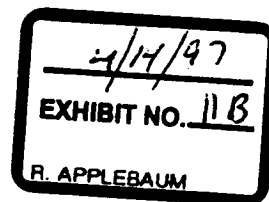
I would again like to apologize to all of you for my mistake. Should there be any questions or uncertainties that you might have regarding this subject, please call me immediately at home or at the office so we can sit down and discuss this further. Thank you for your attention to this matter.

Most Sincerely,

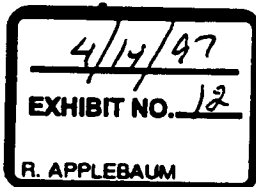
[Signature "Jim"]

J. P. McMahon

JPM/rc



51601 8462



R.J. Reynolds Tobacco Company
Kings-Sale NC 27102
P.O. Box 1000

RJR

January 11, 1990

Principal
Willow Ridge School
480 Willow Ridge Drive
Amherst, NY 14150

Dear Sir or Madam:

A number of your fifth grade students have written R.J. Reynolds Tobacco Company commenting that they do not feel our company should allow the use of our brand names on children's toys and candy cigarettes.

As information, R.J. Reynolds Tobacco Company's policy is not to allow our brand names to be used on toys or candy cigarettes and any current use of our brand names in this fashion is not sanctioned by our company.

Some of the students also commented about the controversies surrounding cigarette smoking. The tobacco industry considers smoking to be a custom for those adults who derive pleasure from it. We believe that whether to smoke or not is a decision that should be freely made by individuals who have reached the age of mature judgment. Accordingly, our advertising is directed to adult smokers and not younger people.

The tobacco industry is also concerned about the charges being made that smoking is responsible for so many serious diseases. Long before the present criticism began, the tobacco industry, in a sincere attempt to determine what harmful effects, if any, smoking might have on human health, established The Council for Tobacco Research--USA. The industry has also supported research grants directed by the American Medical Association. Over the years the tobacco industry has given in excess of \$162 million to independent research on the controversies surrounding smoking -- more than all the voluntary health associations combined.

Despite all the research going on, the simple and unfortunate fact is that scientists do not know the cause or causes of the chronic diseases reported to be associated with smoking. The

2599

51601 8463

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Under section 501(c) of the Internal Revenue Code (except black lung benefit trust or private foundation) or section 4947(a)(1) charitable trust

1992

Department of the Treasury
Internal Revenue Service

Note: The organization may have to use a copy of this return to satisfy state reporting requirements.

This form is
Open to Public
Inspection

A For the calendar year 1992, or fiscal year beginning 11/01/92, 1992, and ending 10/31/93, 19

Please see IRS label or prior or type. See Specific instructions.	B Name of organization		C Employer identification number
	THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.		13-2671498
	Number and street (or P.O. box no. if mail is not delivered to street address) Room/suite		D State registration number
	900 THIRD AVENUE		
City, town, or post office, state, and ZIP code			
NEW YORK, NEW YORK 10022		E If address changed, check box <input type="checkbox"/>	

F Check type of organization - Except under section ☒ 501(c) (06) (insert number), OR ☐ section 4947(a)(1) charitable trustG If exemption application pending, check box ☐H(a) Is this a group return filed for affiliates? ☐ Yes ☒ NoI If either box in H is checked "Yes," enter four-digit group exemption number (GEN) ☐(b) If "Yes," enter the number of affiliates for which this return is filed: ☐J Accounting method: ☐ Cash ☒ Accrual(c) Is this a separate return filed by an organization covered by a group ruling? ☐ Yes ☒ NoOther (specify) ☐K Check here ☐ If the organization's gross receipts are normally not more than \$25,000. The organization need not file but if it received a Form 990 Package in the mail, it should file a return without financial data. Some states require.

Note: Form 990EZ may be used by organizations with gross receipts less than \$100,000 and total assets less than \$250,000

Part I Statement of Revenue, Expenses, and Changes in Net Assets or Fund Balances

Revenue	1 Contributions, gifts, grants, and similar amounts received:		
	a Direct public support	1a	
	b Indirect public support	1b	
	c Government grants	1c	
	d Total (add lines 1a through 1c) (attach schedule - see instructions)	1d	
Revenue	2 Program service revenue (from Part VII, line 93)		2
	3 Membership dues and assessments (see instructions)		3
	4 Interest on savings and temporary cash investments		4
	5 Dividends and interest from securities		5
	6a Gross rents	6a	
	b Less: rental expenses	6b	
	c Net rental income or (loss)	6c	
	7 Other investment income (describe)		7
	8a Gross amount from sale of assets other than inventory	8a	
	b Less: cost or other basis and sales expenses	8b	
c Gain or (loss) (attach schedule)	8c		
d Net gain or (loss) (combine line 8c, columns (A) and (B))	8d		
Revenue	9 Special fundraising events and activities (attach schedule - see instructions):		
	a Gross revenue (not including \$ of contributions)	9a	
	b Less: expenses	9b	
	c Net income	9c	
	10a Gross sales, less returns and allowances	10a	
	b Less: cost of goods sold	10b	
	c Gross profit or (loss) (attach schedule)	10c	
	11 Other revenue (from Part VII, line 103)	11	
	12 Total revenue (add lines 2, 3, 4, 5, 6c, 7, 8d, 9c, 10c, and 11)	12	25,628,848.
	Expenses	13 Program services (from line 2, column (B)) (see instructions)	
14 Management and general (from line 44, column (C)) (see instructions)		14	
15 Fundraising (from line 44, column (D)) (see instructions)		15	
16 Payments to affiliates (attach schedule - see instructions)		16	
17 Total expenses (add lines 13 and 14, column (A))		17	
Net Assets	18 Excess or (deficit) for the year (subtract line 17 from line 12)		18
	19 Net assets or fund balances at beginning of year (from line 74, column (A))		19
	20 Other changes in net assets or fund balances (attach explanation)		20
	21 Net assets or fund balances at end of year (combine lines 18, 19, and 20)		21

For Paperwork Reduction Act Notice, see page 1 of the separate instructions.

Form 990 (1992)

Form 990 (1992)

Page 2

Part II Statement of Functional Expenses

All organizations must complete column (A). Columns (B), (C), and (D) are required for section 501(c)(3) and (4) organizations and 4947(a)(1) charitable trusts but optional for others. (See instructions.)

Do not include amounts reported on line 5b, 5c, 9b, 10b, or 16 of Part I.	(A) Total	(B) Program services	(C) Management and general	(D) Fundraising
22 Grants and allocations (attach schedule)	22 19,486,185.	19,486,185.		
23 Specific assistance to individuals (attach schedule)	23			
24 Benefits paid to or for members (attach schedule)	24			
25 Compensation of officers, directors, etc.	25 555,633.		555,633.	
26 Other salaries and wages	26 545,516.		545,516.	
27 Pension plan contributions	27 129,528.		129,528.	
28 Other employee benefits	28 269,680.		269,680.	
29 Payroll taxes	29 62,478.		62,478.	
30 Professional fundraising fees	30			
31 Accounting fees	31			
32 Legal fees	32			
33 Supplies	33 6,827.		6,827.	
34 Telephone	34 14,902.		14,902.	
35 Postage and shipping	35 12,483.		12,483.	
36 Occupancy	36 319,833.		319,833.	
37 Equipment rental and maintenance	37			
38 Printing and publications	38 129,433.		129,433.	
39 Travel	39			
40 Conferences, conventions, and meetings	40			
41 Interest	41			
42 Depreciation, depletion, etc. (attach schedule)	42			
43 Other expenses (itemize): a STMT 1	43a 3,958,470.		3,958,470.	
b	43b			
c	43c			
d	43d			
e	43e			
f	43f			
44 Total functional expenses (add lines 22 through 43. Organizations completing columns (B)-(D), carry these totals to lines 13-15.)	44 25,490,968.	19,486,185.	6,004,783.	

Reporting of Joint Costs. - Did you report in column (B) (Program services) any joint costs from a combined educational campaign and fundraising solicitation? ☐ Yes ☒ No

If "Yes," enter (i) the aggregate amount of these joint costs \$ _____; (ii) the amount allocated to program services \$ _____; (iii) the amount allocated to management and general \$ _____; and (iv) the amount allocated to fundraising \$ _____.

Part III Statement of Program Service Accomplishments (See instructions.)

Describe what was achieved in carrying out the organization's exempt purposes. Fully describe the services provided; the number of persons benefited; or other relevant information for each program title. Section 501(c)(3) and (4) organizations and section 4947(a)(1) charitable trusts must also enter the amount of grants and allocations to others.

Expenses
Required for 501(c)(3)
and (4) organizations and
4947(a)(1) trusts;
optional for others

a AUTHORIZED RESEARCH & CONTRACTS

	Grants and allocations \$ 19,486,185.)	19,486,185.
b	Grants and allocations \$ BROOKHAVEN SERVICE CENTER	
c	Grants and allocations \$ PHOTO COPY	
d	Grants and allocations \$ DO NOT PROCESS	
e	Grants and allocations \$ PUBLIC INSPECTION COPY	
f	Grants and allocations \$	
g	Grants and allocations \$	
h	Grants and allocations \$	
i	Grants and allocations \$	
j	Grants and allocations \$	
k	Grants and allocations \$	
l	Grants and allocations \$	
m	Grants and allocations \$	
n	Grants and allocations \$	
o	Grants and allocations \$	
p	Grants and allocations \$	
q	Grants and allocations \$	
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s	Grants and allocations \$	
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u	Grants and allocations \$	
v	Grants and allocations \$	
w	Grants and allocations \$	
x	Grants and allocations \$	
y	Grants and allocations \$	
z	Grants and allocations \$	
aa	Grants and allocations \$	
ab	Grants and allocations \$	
ac	Grants and allocations \$	
ad	Grants and allocations \$	
ae	Grants and allocations \$	
af	Grants and allocations \$	
ag	Grants and allocations \$	
ah	Grants and allocations \$	
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by	Grants and allocations \$	
bz	Grants and allocations \$	
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cn	Grants and allocations \$	
co	Grants and allocations \$	
cp	Grants and allocations \$	
cq	Grants and allocations \$	
cr	Grants and allocations \$	
cs	Grants and allocations \$	
ct	Grants and allocations \$	
cu	Grants and allocations \$	
cv	Grants and allocations \$	
cw	Grants and allocations \$	
cx	Grants and allocations \$	
cy	Grants and allocations \$	
cz	Grants and allocations \$	
da	Grants and allocations \$	
db	Grants and allocations \$	
dc	Grants and allocations \$	
dd	Grants and allocations \$	
de	Grants and allocations \$	
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Part IV Balance Sheets

Note: Where required, attached schedules and amounts within the description column should be for end-of-year amounts only.		(A) Beginning of year	(B) End of year
Assets			
45 Cash - noninterest-bearing		118,925.45	154,411.
46 Savings and temporary cash investments		897,145.48	1,151,573.
47a Accounts receivable	47a 13,566,503.		
b Less: allowance for doubtful accounts	47b	14,448,219.47c	13,566,503.
48a Pledges receivable	48a		
b Less: allowance for doubtful accounts	48b		
49 Grants receivable			
50 Receivables due from officers, directors, trustees, and key employees (attach schedule)			
51a Other notes and loans receivable (attach schedule)	51a		
b Less: allowance for doubtful accounts	51b		
52 Inventories for sale or use			
53 Prepaid expenses and deferred charges		230,982.53	238,433.
54 Investments - securities (attach schedule)			
55a Investments - land, buildings, and equipment basis			
b Less: accumulated depreciation (attach schedule)	55b		
56 Investments - other (attach schedule)			
57a Land, buildings, and equipment basis	57a		
b Less: accumulated depreciation (attach schedule)	57b		
58 Other assets (describe)			
59 Total assets (add lines 45 through 58) (must equal line 75)		15,695,271.59	15,110,920.
Liabilities			
60 Accounts payable and accrued expenses		328,106.80	301,542.
61 Grants payable		14,590,803.81	13,843,619.
62 Support and revenue designated for future periods (attach schedule)			
63 Loans from officers, directors, trustees, and key employees (attach schedule)			
64 Mortgages and other notes payable (attach schedule)			
65 Other liabilities (describe) SEE STATEMENT 2		210,324.85	224,863.
66 Total liabilities (add lines 60 through 65)		15,129,233.86	14,369,924.
Fund Balances or Net Assets			
Organizations that use fund accounting, check here <input checked="" type="checkbox"/> and complete lines 67 through 70 and lines 74 and 75 (see instructions).			
67a Current unrestricted fund		560,152.87a	735,110.
b Current restricted fund			
68 Land, buildings, and equipment fund			
69 Endowment fund			
70 Other funds (describe) SEE STATEMENT 3		5,886.70	5,886.
Organizations that do not use fund accounting, check here <input type="checkbox"/> and complete lines 71 through 75 (see instructions).			
71 Capital stock or trust principal			
72 Paid-in or capital surplus			
73 Retained earnings or accumulated income			
74 Total fund balances or net assets (add lines 67a through 70 OR lines 71 through 73; column (A) must equal line 19 and column (B) must equal line 21)		566,038.74	740,996.
75 Total liabilities and fund balances/net assets (add lines 66 and 74)		15,695,271.75	15,110,920.

Form 990 is available for public inspection and, for some people, serves as the primary or sole source of information about a particular organization. How the public perceives an organization in such cases may be determined by the information presented on its return. Therefore, please make sure the return is complete and accurate and fully describes your organization's programs and accomplishments.

Part V List of Officers, Directors, Trustees, and Key Employees List each one even if not compensated. See instructions.)

(A) Name and address	(B) Title and average hours per week devoted to position	(C) Compensation (If not paid, enter -0-)	(D) Contributions to employee benefit plans	(E) Expense account and other allowances
SEE STATEMENT 4		555,633		

Did any officer, director, trustee, or key employee receive aggregate compensation of more than \$100,000 from your organization and all related organizations, of which more than \$10,000 was provided by the related organizations? ☐ Yes ☒ No
If "Yes," attach schedule (see instructions).

Part VI Other Information

Note: Section 501(c)(3) organizations and section 4947(a)(1) trusts must also complete and attach Schedule A (Form 990).

	Yes	No
76 Did the organization engage in any activity not previously reported to the Internal Revenue Service? If "Yes," attach a detailed description of each activity.	76	X
77 Were any changes made in the organizing or governing documents, but not reported to the IRS? If "Yes," attach a conformed copy of the changes.	77	X
78a Did the organization have unrelated business gross income of \$1,000 or more during the year covered by this return? b If "Yes," has it filed a tax return on Form 990-T, Exempt Organization Business Income (or Return, for this year)? c At any time during the year, did the organization own a 50% or greater interest in a taxable corporation or partnership? If "Yes," complete Part IX.	78a 78b 78c	X N/A X
79 Was there a liquidation, dissolution, termination, or substantial operation during the year? (See instructions.) If "Yes," attach a statement as described in the instructions.	79	X
80a Is the organization related (other than by association with a statewide or nationwide organization) through common membership, governing bodies, trustees, officers, etc., to any other exempt or non-exempt organization? (See instructions.) b If "Yes," enter the name of the organization: _____ and check whether it is <input type="checkbox"/> exempt OR <input type="checkbox"/> nonexempt.	80a	X
81a Enter amount of political expenditures, direct or indirect, as described in the instructions. [81a]		
b Did the organization file Form 1120-POL, U.S. Income Tax Return for Certain Political Organizations, for this year?	81b	X
82a Did the organization receive donated services or the use of materials, equipment, or facilities at no charge or at substantially less than fair rental value? b If "Yes," you may indicate the value of these items here. Do not include this amount as revenue in Part I or as an expense in Part II. See instructions for reporting in Part III.	82a 82b	X N/A
83a Did anyone request to see either the organization's annual return or exemption application (or both)? b If "Yes," did the organization comply as described in the instructions? (See General Instruction L.)	83a 83b	X N/A
84a Did the organization solicit any contributions or gifts that were not tax deductible? b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? (See General Instruction M.)	84a 84b	X N/A
85a Section 501(c)(5) or (6) organizations. - Did the organization spend any amounts in attempts to influence public opinion about legislative matters or referendums? (See instructions and Regulations section 1.152-2(a).)	85a	X
b If "Yes," enter the total amount spent for this purpose: _____		
86 Section 501(c)(7) organizations. - Enter:		
a Initiation fees and capital contributions included on line 12.	86a	N/A
b Gross receipts, included on line 12, for public use of club facilities (See instructions.)	86b	N/A
c Does the club's governing instrument or any written policy statement provide for discrimination against any person because of race, color, or religion? (If "Yes," attach statement. See instructions.)	86c	N/A
87 Section 501(c)(12) organizations. - Enter amount of:		
a Gross income received from members or shareholders.	87a	N/A
b Gross income received from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	87b	N/A
88 Public interest law firms. - Attach information described in the instructions.		
89 List the states with which a copy of this return is filed: _____		
90 During this tax year did the organization maintain any part of its accounting/tax records on a computerized system?	90	X
91 The books are in care of: JAMES F. GLENN, MD Telephone no. 212-421-8885 Located at: 900 THIRD AVENUE, NEW YORK, NY ZIP code 10022		
92 Section 4947(a)(1) charitable trusts filing Form 990 in lieu of Form 1041, U.S. Fiduciary Income Tax Return, should check here <input type="checkbox"/> and enter the amount of tax-exempt interest received or accrued during the tax year: [92]		

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Part VII: Analysis of Income-Producing Activities

Enter gross amounts unless otherwise indicated.

Enter gross amounts unless otherwise indicated.		Unrelated business income		Excluded by section 512, 513, or 514		(e) Related or exempt function income (See instructions.)
	(a) Business Code	(b) Amount	(c) Exclusion code	(d) Amount		
93 Program service revenue:						
(a) _____						
(b) _____						
(c) _____						
(d) _____						
(e) _____						
(f) _____						
(g) Fees from government agencies . .						
94 Membership dues and assessments . .						25,628,848.
95 Interest on savings and temporary cash investments			14	37,078.		
96 Dividends and interest from securities .						
97 Net rental income or (loss) from real estate:						
(a) debt-financed property						
(b) net debt-financed property						
98 Net rental income or (loss) from personal property						
99 Other investment income						
100 Gains or (loss) from sales of assets other than inventory						
101 Net income from special fundraising events						
102 Gross profit or (loss) from sales of inventory .						
103 Other revenue: (a) _____						
(b) _____						
(c) _____						
(d) _____						
(e) _____						
104 Subtotal (add columns (b), (d), and (e)) .				37,078.		25,628,848.
105 TOTAL (add line 104, columns (b), (d), and (e))						25,665,926.

Note: Line 105 plus line 1d, Part I, should equal the amount on line 12, Part U

Part VIII Relationship of Activities to the Accomplishment of Exempt Purposes

[illegible]

Part IX Information Regarding Taxable Subsidiaries (Complete this Part if the "Yes" box on 78c is checked)

Name, address, and employer identification number of corporation or partnership	Percentage of ownership interest	Nature of business activities	Total income	End-of-year assets

Please
Sign
Here

Under penalties of perjury, I declare that I have discussed this report, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Signature of officer JAMES F. GLINN

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CHAIRMAN & PRESIDENT'

474

**Paid
Preparer's
Use Only**

Preparer's
Signature:

**Firm's name for
years if self-employed
and address**

COOPERS & LYBAND

~~1301 AVENUE OF THE AMERICAS, N.Y., N.Y. 10019 6213~~

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Check if self- employed	
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FORM 990, PART II - OTHER EXPENSES

DESCRIPTION	TOTAL	MANAGEMENT AND GENERAL
PROFESSIONAL FEES	3,035,348.	3,035,348.
RESEARCH & ANALYSIS	95,302.	95,302.
PUBLIC RELATIONS	127,052.	127,052.
BANK SERVICE CHARGES	17,914.	17,914.
EXPENSES: OFFICERS, SCIENTIFIC DIRECTOR & ASSISTANTS	129,870.	129,870.
PROVISION FOR DEFERRED COMPENSATION	45,803.	45,803.
PER DIEM ALLOWANCES & EXPENSES RE: SCIENTIFIC ADVISORY BOARD	506,185.	506,185.
MISCELLANEOUS EXPENSE	996.	996.
TOTALS	3,958,470.	3,958,470.

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FORM 990, PART IV - OTHER LIABILITIES

DESCRIPTION -----	BEGINNING OF YEAR -----	END OF YEAR -----
DEFERRED COMPENSATION PAYABLE	210,324.	224,863.
TOTAL	<u>210,324.</u>	<u>224,863.</u>

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FORM 990, PART IV - OTHER FUNDS

DESCRIPTION -----	BEGINNING OF YEAR -----	END OF YEAR -----
SPECIAL PROJECTS FUND	5,886.	5,886.
TOTAL	<u>5,886.</u>	<u>5,886.</u>

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FORM 990, PART V - LIST OF OFFICERS, DIRECTORS, AND TRUSTEES

NAME AND ADDRESS	TITLE/ TIME DEVOTED	COMPENSATION	CONTRIBUTIONS TO EMPLOYEE BENEFIT PLANS	EXPENSE ACCOUNT AND OTHER ALLOWANCES
JAMES F. GLENN 900 THIRD AVENUE NEW YORK, NEW YORK 10022	CHMAN/PRE FULL	250,000.	90,634.	NONE
HARMON MCALLISTER 900 THIRD AVENUE NEW YORK, NEW YORK 10022	VP: RESEAR FULL	110,833.	43,077.	NONE
LORENAINE POLLICE 900 THIRD AVENUE NEW YORK, NEW YORK 10022	SEC-TREAS FULL	67,167.	24,340.	NONE
ARTHUR EISENBERG 900 THIRD AVENUE NEW YORK, NEW YORK 10022	ASST SECY FULL	83,833.	30,389.	NONE
ROBERT O'KEEFE 900 THIRD AVENUE NEW YORK, NEW YORK 10022	ASST TRES FULL	35,800.	12,977.	NONE
TOTAL COMPENSATION		555,633.		

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Department of the Treasury
Internal Revenue ServiceUnder section 501(c) (except black lung benefit trust or private foundation) of the Internal Revenue Code or section 4947(a)(1) trust
Note: You may be required to use a copy of this return to satisfy state reporting requirements. See instruction D.

1988

For the calendar year 1988, or fiscal year beginning 11-01, 1988, and ending

10-31, 19 89

Name of organization 9018 1503 THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.	A Employer identification number (see instruction U) 13-2671498
Address (number and street) 900 THIRD AVENUE	B State registration number (see instruction D)
City or town, state, and ZIP code NEW YORK, NEW YORK 10022	C Section 4947(a)(1) trusts filing this form in lieu of Form 1041, check here <input type="checkbox"/> (see instruction C)(1)

Check type of organization - (Exempt under section) ☒ 501(c) (6) (insert number), OR ☐ section 4947(a)(1) trust

Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify) _____

Is this a group return (see instruction A) filed for affiliates? ☐ Yes ☒ No
If "Yes," enter the number of affiliates for which this return is filed _____

G If "Yes" to either, give four-digit group exemption number (GEN) _____

Is this a separate return filed by a group affiliate? ☐ Yes ☒ No

☐ Check here if your gross receipts are normally not more than \$25,000 (see instruction B11). You do not have to file a completed return with IRS but should file a return without financial data if you were mailed a Form 990 Package (see instruction A). Some states may require a completed return.

☐ Check here if gross receipts are normally more than \$25,000 and line 12 is \$25,000 or less. Complete Parts I (except lines 13-15), III, IV, VI, and VII and only the indicated items in Parts II and V (see instruction B). If line 12 is more than \$25,000, complete the entire return.

1(c)(3) organizations and 4947(a)(1) trusts must also complete and attach Schedule A (Form 990). (See instructions.)

These columns are optional - see instructions

PART I Statement of Support, Revenue, and Expenses and Changes in Fund Balances		(A) Total	(B) Unrestricted/Expendable	(C) Restricted/Nonexpendable
1 Contributions, gifts, grants, and similar amounts received:				
a Direct public support	1,060,000.			
b Indirect public support				
c Government grants				
d Total (add lines 1a through 1c) (attach schedule - see instructions)		1,060,000.		
2 Program service revenue (from Part IV, line f)				
3 Membership dues		17,555,020.		
4 Interest on savings and temporary investments		127,394.		
5 Dividends and interest from securities				
6a Gross rents				
b Minus: rental expenses				
c Net rental income (loss)				
7 Other investment income (Describe _____)				
8a Gross amount from sale of assets other than inventory	Securities Other			
b Minus: cost or other basis and sales expenses				
c Gain (loss) (attach schedule)				
9 Special fundraising events and activities (attach schedule - see instructions):				
a Gross revenue (not including \$ of contributions reported on line 1a)				
b Minus: direct expenses				
c Net income (line 9a minus line 9b)				
10a Gross sales minus returns and allowances				
b Minus: Cost of goods sold (attach schedule)				
c Gross profit (loss)				
11 Other revenue (from Part IV, line g)		121,893.		
12 Total revenue (add lines 1d, 2, 3, 4, 5, 6c, 7, 8c, 9c, 10c, and 11)		18,864,307.		
13 Program services (from line 44, column (B)) (see instructions)		13,843,611.		
14 Management and general (from line 44, column (C)) (see instructions)		3,504,237.		
15 Fundraising (from line 44, column (D)) (see instructions)				
16 Payments to affiliates (attach schedule - see instructions)				
17 Total expenses (add lines 16 and 44, column (A))		17,347,848.		
18 Excess (deficit) for the year (subtract line 17 from line 12)		1,516,459.		
19 Fund balances or net worth at beginning of year (from line 74, column (A))		279,015.		
20 Other changes in fund balances or net worth (attach explanation)				
21 Fund balances or net worth at end of year (add lines 18, 19, and 20)		1,795,474.		

Paperwork Reduction Act Notice, see page 1 of the instructions.

Form 990 (1988)

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Part II

Statement of Functional Expenses

All organizations must complete column (A). Columns (B), (C), and (D) are required for most sections 501(c)(3) and (e)(4) organizations and 4947(b)(1) trusts but optional for others. (See instructions.)

Do not include amounts reported on lines 6a, 8b, 9b, 10b, or 16 of Part I	(A) Total	(B) Program services	(C) Management and general	(D) Fundraising
22 Grants and allocations (attach schedule)	13,809,352.	13,809,352.		
23 Specific assistance to individuals	34,259.	34,259.		
24 Benefits paid to or for members				
25 Compensation of officers, directors, etc.	311,561.		311,561.	
26 Other salaries and wages	619,801.		619,801.	
27 Pension plan contributions	121,246.		121,246.	
28 Other employee benefits	179,977.		179,977.	
29 Payroll taxes	50,808.		50,808.	
30 Professional fundraising fees				
31 Accounting fees	31,684.		31,684.	
32 Legal fees	872,767.		872,767.	
33 Supplies	7,400.		7,400.	
34 Telephone	13,574.		13,574.	
35 Postage and shipping	13,042.		13,042.	
36 Occupancy	369,898.		369,898.	
37 Equipment rental and maintenance				
38 Printing and publications	96,746.		96,746.	
39 Travel				
40 Conferences, conventions, and meetings	400,402.		400,402.	
41 Interest				
42 Depreciation, depletion, etc. (attach schedule)				
43 Other expenses (itemize): a				
b SEE STATEMENT 3	415,331.		415,331.	
c				
d				
e				
f				
44 Total functional expenses (add lines 22 through 43) Organizations completing columns B-D, carry these totals to lines 13-16.	17,347,848.	13,843,611.	3,504,237.	

Part III Statement of Program Services Rendered

List each program service title on lines a through d; for each, identify the service output(s) or product(s), and report the quantity provided. Enter the total expenses attributable to each program service and the amount of grants and allocations included in that total. (See instructions for Part III.)

Expenses Optional for some organizations - see instructions

AUTHORIZED RESEARCH & CONTRACTS		
	(Grants and allocations \$ 809,352.)	13,809,352.
AUTHORIZED SPECIAL PROJECTS		
	(Grants and allocations \$ 34,259.)	34,259.
	(Grants and allocations \$)	
	(Grants and allocations \$)	
Other program service activities (attach schedule)	(Grants and allocations \$)	
Total (add lines a through e) (should equal line 44, column (B))		13,843,611.

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art IV Program Service Revenue and Other Revenue (State nature.)

Fees from government agencies

REVERSAL OF RETIREMENT BENEFITS ACCRUAL

Program
service revenueOther
revenue

121,893.

Total program service revenue (enter here and on line 2)

Total other revenue (enter here and on line 11)

121,893.

art V Balance Sheets

If line 12 or Column (B) of line 59 is more than \$25,000, complete the entire balance sheet. If line 12, Part I, and Column (B) of line 59 are \$25,000 or less, you may complete only lines 59, 66, 74, and 75. See instructions.

Note: Columns (C) and (D) are optional. Columns (A) and (B) must be completed to the extent applicable. Where required, attached schedules should be for end-of-year amounts only.

	(A) Beginning of year	End of year		
		(B) Total	(C) Unrestricted/Expendable	(D) Restricted/Nonexpendable
Assets				
Cash - non-interest bearing	403,951.	181,584.		
Savings and temporary cash investments	1,091,583.	671,600.		
Accounts receivable ▶ 12,455,934.				
allowance allowance for doubtful accounts ▶	10,332,476.	12,455,934.		
Pledges receivable ▶				
allowance allowance for doubtful accounts ▶				
Grants receivable				
Receivables due from officers, directors, trustees, and key employees (attach schedule)				
Other notes and loans receivable ▶				
allowance allowance for doubtful accounts ▶				
Inventories for sale or use				
Prepaid expenses and deferred charges	1,646.	1,646.		
Investments - securities (attach schedule)				
Investments - land, buildings, and equipment basis ▶				
allowance accumulated depreciation ▶ (attach schedule)				
Investments - other (attach schedule)				
Land, buildings, and equipment basis ▶				
allowance accumulated depreciation ▶ (attach schedule)				
Other assets ▶ SEE STATEMENT 4	1,525.	1,525.		
Total assets (add lines 45 through 58)	11,831,181.	13,312,289.		
Liabilities				
Accounts payable and accrued expenses	183,175.	117,659.		
Grants payable	10,692,409.	11,211,712.		
Support and revenue designated for future periods (attach sched.)				
Loans from officers, directors, trustees, and key employees (attach schedule)				
Mortgages and other notes payable (attach schedule)				
Other liabilities ▶ SEE STATEMENT 5	676,582.	187,444.		
Total liabilities (add lines 60 through 65)	11,552,166.	11,516,815.		
Fund Balances or Net Worth				
organizations that use fund accounting, check here ▶ <input checked="" type="checkbox"/>				
and complete lines 67 through 70 and lines 74 and 75.				
a Current unrestricted fund				
b Current restricted fund				
Land, buildings, and equipment fund				
Endowment fund				
Other funds (Describe) ▶ SEE STATEMENT 6	279,015.	1,795,474.		
organizations that do not use fund accounting, check here ▶ <input type="checkbox"/>				
and complete lines 71 through 75.				
Capital stock or trust principal				
Paid-in or capital surplus				
Retained earnings or accumulated income				
Total fund balances or net worth (see instructions)	279,015.	1,795,474.		
Total liabilities and fund balances/net worth (see instructions)	11,831,181.	13,312,289.		

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Part VI List of Officers, Directors, and Trustees (List each one whether compensated or not. See instructions.)

(A) Name and address	(B) Title and average hours per week devoted to position	(C) Compensation (if not paid, enter zero)	(D) Contributions to employee benefit plans	(E) Expense account and other allowances
SEE STATEMENT 1				

Part VII Other Information

3 Has the organization engaged in any activities not previously reported to the Internal Revenue Service? ☒ Yes ☒ No
If "Yes," attach a detailed description of the activities.

7 Have any changes been made in the organizing or governing documents, but not reported to IRS? ☒ Yes ☒ No
If "Yes," attach a conformed copy of the changes.

3 If the organization had income from business activities, such as those reported on lines 2, 9, and 10 (among others), but NOT reported on Form 990-T, attach a statement explaining your reason for not reporting the income on Form 990-T.

a Did the organization have unrelated business gross income of \$1,000 or more during the year covered by this return? ☒ Yes ☒ No
b If "Yes," have you filed a tax return on Form 990-T, Exempt Organization Business Income Tax Return, for this year? ☒ Yes ☒ No

3 Was there a liquidation, dissolution, termination, or substantial contraction during the year? (See instructions.) ☒ Yes ☒ No
If "Yes," attach a statement as described in the instructions.

2a Is the organization related (other than by association with a statewide or nationwide organization) through common membership, governing bodies, trustees, officers, etc., to any other exempt or nonexempt organization? (See instructions.) ☒ Yes ☒ No
If "Yes," enter the name of the organization: _____ and check whether it is ☐ exempt OR ☐ nonexempt

1 a Enter amount of political expenditures, direct or indirect, as described in the instructions N/A

b Did you file Form 1120-POL, U.S. Income Tax Return for Certain Political Organizations, for this year? N/A

2 Did your organization receive donated services or the use of materials, equipment, or facilities at no charge or at substantially less than fair rental value? N/A
If "Yes," you may indicate the value of these items here. Do not include this amount as support in Part I or as an expense in Part II. See instructions for reporting in Part III.

8 Section 501(c)(5) or (6) organizations. - Did the organization spend any amounts in attempts to influence public opinion about legislative matters or referendums? (See instructions and Regulations section 1.162-20(c).) ☒ Yes ☒ No
If "Yes," enter the total amount spent for this purpose: _____

9 Section 501(c)(7) organizations. - Enter: a Initiation fees and capital contributions included on line 12 N/A
b Gross receipts, included in line 12, for public use of club facilities (See instructions.) N/A
c Does the club's governing instrument or any written policy statement provide for discrimination against any person because of race, color, or religion? (See instructions.) N/A

5 Section 501(c)(12) organizations. - Enter amount of:
a Gross income received from members or shareholders N/A
b Gross income received from other sources (do not net amounts due or paid to other sources against amounts due or received from them) N/A

3 Public interest law firms. - Attach information described in the instructions.

7 List the states with which a copy of this return is filed: NEW YORK

39 During this tax year did you maintain any part of your accounting/tax records on a computerized system? ☒ Yes ☒ No

3 The books are in care of: ROBERT GERTENBACH Telephone no. 212-421-8885
Located at: 900 THIRD AVENUE, NEW YORK, NY 10022

19 Section 4947(a)(1) trusts filing Form 990 in lieu of Form 1041. - Enter the amount of tax-exempt interest received or accrued during the tax year: _____

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Signature of officer: R. F. Gertenbach Date: 3/29/90 Title: President

Preparer's signature: [Signature] Date: 3/29/90 Check if self-employed: ☐

Firm's name (or yours if self-employed) and address: COOPERS & LYBRAND
1251 AVE OF THE AMERICAS
NEW YORK, NEW YORK

ZIP code: 10020

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THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.
NEW YORK, NEW YORK 10022

STATEMENT 1
13-2671498

LIST OF OFFICERS, DIRECTORS, AND TRUSTEES
=====

NAME AND ADDRESS	TITLE AND TIME	COMPENSATION	CONTRIB TO EMPLOYEE BENEFIT PLAN	EXPENSE ACCOUNT
J. HOBBS 00 THIRD AVENUE EW YORK, NEW YORK 10022	CHAIRMAN PART	98,333.	NONE	NONE
DBERT GERTENBACH 00 THIRD AVENUE EW YORK, NEW YORK 10022	PRESIDENT FULL	121,645.	NONE	NONE
STORR 00 THIRD AVE EW YORK, NEW YORK 10022	TREASURER PART	NONE	NONE	NONE
J. JENKINS 00 THIRD AVENUE EW YORK, NEW YORK 10022	ASST SECY FULL	45,833.	NONE	NONE
ORRAINE POLLICE 00 THIRD AVENUE EW YORK, NEW YORK 10022	ASST TRES FULL	45,750.	NONE	NONE

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STMT 1

THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.
 NEW YORK, NEW-YORK 10022

STATEMENT 2
 13-2671498

REVENUES AND EXPENSES

=====	
INTEREST REVENUE	
INTEREST INCOME-GENERAL FUND	122,603.
INTEREST INCOME-SPEC. PROJECTS FUND	4,791.

TOTAL	127,394.
	=====

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THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.
NEW YORK, NEW YORK 10022STATEMENT 3
13-2671498OTHER EXPENSE
=====

MISCELLANEOUS EXPENSES	5,395.
RESEARCH & ANALYSIS	4,717.
PUBLIC RELATIONS	145,095.
PHOTOSTATS & MULTILITHING	31,881.
BANK SERVICE CHARGES	10,217.
INSURANCE	172,223.
PROVISION FOR DEFERRED COMPENSATION	45,803.

TOTAL	415,331.
	=====

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THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.
NEW YORK, NEW YORK 10022

STATEMENT 4
13-2671498

BALANCE SHEET DETAIL

END OF YEAR
BOOK VALUE

OTHER ASSETS
DEPOSITS

1,525.

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THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.
NEW YORK, NEW YORK 10022

STATEMENT 5
13-2671498

BALANCE SHEET DETAIL

END OF YEAR
BOOK VALUE

OTHER LIABILITIES

SEE SCHEDULE

187,444.

OTHER FUNDS

SEE SCHEDULE

1,795,474.

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THE COUNCIL FOR TOBACCO RESEARCH-U.S.A., INC.
NEW YORK, NEW YORK 10022

STATEMENT 6
13-2671498

***FEDERAL FOOTNOTES

FORM 990, PART V, LINE 65:

	10-31-88	10-31-89
OTHER LIABILITIES:		
ESTIMATED LIABILITY FOR DEFERRED COMPENSATION	443,208.	187,444.
ESTIMATED LIABILITY FOR SUPP. RETIREMENT BENEFITS	233,374.	
	<u>676,582.</u>	<u>187,444.</u>

FORM 990, PART V, LINE 70:

OTHER FUNDS:

GENERAL FUND	1,506,980.	1,992,907.
SPECIAL PROJECTS FUND	<u>-1,227,965.</u>	<u>-197,433.</u>
	<u>279,015.</u>	<u>1,795,474.</u>

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PUBLIC SMOKING

In 1971, Jesse L. Steinfeld, M.D., then U.S. Surgeon General, advocated the prohibition of smoking in confined public places, such as restaurants, theaters, airplanes, trains and buses, because the nonsmoker might be injured by ambient tobacco smoke (i.e., tobacco smoke in the atmosphere).

Steinfeld's statement gave anti-smoking groups an effective theme. The anti-smoking organizations adopted the objective that smoking should be made socially unacceptable. They began a mass invasion of state capitals and city halls to argue that laws must be enacted to protect the nonsmoker from ambient tobacco smoke forced on him by smokers in public places.

CHRONOLOGY

The following is a brief sketch of major events at the state and local level subsequent to Steinfeld's clarion call.

- 1970 Ten bills introduced to restrict smoking in public places; none enacted.
- 1971 Twenty-eight bills introduced in five states; two enacted.
- 1972 Sixteen bills proposed in 12 states; two enacted. HEW adopted guidelines which prohibited smoking in conference rooms and auditoriums in its buildings and required no smoking sections in its cafeterias.
- 1973 Thirty-six bills proposed in 18 states; five enacted. Many municipalities enacted restrictive ordinances. The Arizona restrictive law and its promoter, Mrs. Betty Carnes, received wide publicity. The CAB ordered commercial airliners to separate smokers and non-smokers.
- 1974 Sixty-two bills proposed in 29 states; five enacted. Several municipal ordinances restricting smoking also were enacted. The ICC restricted smokers to the rear 20 percent of seating space on interstate buses.
- 1975 One hundred sixty restrictive smoking bills introduced in 48 states; 17 enacted. The Minnesota Clean Indoor Air Act restricted smoking in a broad range of public and commercial areas. The New York Health Department prohibited smoking in public areas, including supermarkets.

4/15/97
EXHIBIT NO. 13
R. APPLEBAUM

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1976

One hundred sixty-one bills proposed in 39 states; eight enacted, including the Utah Clean Indoor Air Act, another broad no smoking bill.—Lawsuits were filed against the Pontiac, Michigan, Stadium Authority and the New Orleans Superdome by anti-smokers seeking to prohibit smoking in the buildings. The court dismissed the Superdome action and the Michigan lawsuit was settled with an agreement that the stadium would request the public not to smoke except in concourses. The ICC prohibited smoking in railroad dining cars and required separate passenger cars for smokers and non-smokers. Donna Shimp sued her employer, New Jersey Bell Telephone Company, and obtained an injunction requiring the company to provide her with a smoke-free working environment. Ms. Shimp was an ex-smoker who claimed she had a rare eye condition which was aggravated by tobacco smoke.

10.

1977

One hundred thirty-six restrictive bills introduced in 44 states, 13 enacted. The General Services Administration (the caretaker for U. S. Government buildings), the State Department and the Department of Defense enacted restrictive smoking guidelines for buildings under their control. The FAA rejected a petition by a Nader group which requested a prohibition against smoking by pilots on the flight deck of airliners. The CAB voted to prohibit pipe and cigar smoking in interstate airlines and announced that it would consider a rule prohibiting cigarette smoking.

11.

1978

As of May 1, 97 restrictive bills were introduced in 25 states, and three were enacted. As a part of HEW's "War on Smoking" program, HEW promulgated new restrictive smoking rules for buildings under its control and announced its intention to urge businesses and state and local governments to adopt restrictive smoking rules. California GASP and Californians for Clean Indoor Air obtained sufficient signatures to place a broad anti-smoking initiative on the ballot for the California general election in November. Twenty-six restrictive measures were proposed in local governments and eight have been enacted. In April the New Jersey Public Health Council added a broad no smoking in public provision to the New Jersey Sanitary Code, which is enforceable as law, effective July 1, 1978. Implementation of the new Code provisions may be delayed at the request of the New Jersey legislature.

12.

Anti-smoking groups have continued to enjoy their greatest successes at the local government level. Most major cities now have restrictive smoking ordinances. There are

13.

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00000 2013

more than 225 local governments with restrictive ordinances reported to the Tobacco Institute. The actual number is probably larger.

THE LAWS AND ENFORCEMENT

Thirty-two states and the District of Columbia have enacted legislation restricting smoking in at least one category of public places. Of those 32 states, the majority have enacted prohibitions or restrictions applicable to elevators, public transportation, theaters, museums, libraries, concert halls, health delivery facilities, health care facilities, government buildings and public meeting places. Six of the 32 states have prohibited smoking or require segregation of smokers in retail stores, food stores, and restaurants. Two states (Minnesota and Utah) extend their restrictions to privately owned places, including offices where more than one person works.

14.

The Minnesota Clean Indoor Air Act is one of the two broadest state restrictive laws in the United States and has become the model for anti-smoking legislation. The law prohibits smoking in public places except in designated smoking areas. The Act defines "public place" as:

15.

...any enclosed, indoor area used by the general public or serving as a place of work, including, but not limited to, restaurants, retail stores, offices and other commercial establishments, public conveyances, educational facilities, hospitals, nursing homes, auditoriums, arenas and meeting rooms, but excluding private, enclosed offices occupied exclusively by smokers even though such offices may be visited by nonsmokers.

Smoking areas may be designated by proprietors of public places, provided that:

16.

...where smoking areas are designated, existing physical barriers and ventilation systems shall be used to minimize the toxic effect of the smoke in adjacent nonsmoking areas.

Current trends in state laws and local ordinances actually enacted are the extension of smoking restrictions to cover government-owned buildings, grocery stores, supermarkets and health care and delivery facilities. The major trend in the bills introduced, reflecting the ambition of anti-smoking supporters, is the extension of restrictions into the workplace, including offices.

17.

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Produced by RIRTC

Reported enforcement activities appear to be the result of either official priorities set by the local administration or, more frequently, random efforts by local GASP chapters to obtain enforcement of the laws.

18.

In Chicago, smoking on Transit Authority trains and buses is punishable by fines of \$50 to \$300. Offenders are tried in "Smokers' Court," where more than 800 people were convicted in 1975. People who could not post the \$25 bond had to spend the night in jail. Even those who could post bond often had to spend several hours in custody before cutting the red tape and winning release. Smokers have been taken bodily from trains because they protested their arrest. Ninety percent of the arrests have involved minority and low income groups.

19.

However, in most cities which have enforced public smoking laws, actions have resulted from private complaints and citizens' arrests made by private individuals, usually members of GASP. Most reports of enforcement from citizens' arrests come from California cities. The laws of most states do not authorize a citizen's arrest for violation of no smoking laws, but in California smokers can be arrested by fellow citizens.

20.

Yet the primary impact of smoking restriction laws may be the creation of a no-smoking norm in public places. The Commissioner of Dade County, Florida, admitted that that county's anti-smoking ordinance was virtually unenforceable but added:

21.

But it's being morally enforced; it's the people, the people in the elevators, the clerks in the stores and the nonsmokers in the check-out lines, who by their remarks to offenders are enforcing the law. It's being enforced by people who want to obey the law and I'd say it was 85% to 90% effective.

The impact of no-smoking laws on the cigarette market has not been accurately measured. However, to gauge the impact it is helpful to remember that the average smoker in the United States consumes 1.5 packs per day. If it is assumed that smoking prohibitions in public places caused the average smoker to consume one less cigarette per day, total consumption in the U.S. would be reduced by 1/30th.

22.

THE MEDICAL FACTS

In 1971, Jesse L. Steinfeld, M.D., who served as U.S. Surgeon General from 1968 to 1973, said:

23.

Evidence is accumulating that the nonsmoker may have untoward effects from the pollution his smoking neighbor forces upon him.... It is high time to ban smoking from all confined public places such as restaurants, theaters, airplanes, trains, and buses....

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There was no evidence in the speech, and there had been no evidence in previous Public Health Service (PHS) reports to Congress on Smoking and health signed by the Surgeon General (commonly called the Surgeon General's Report). In fact, a previously published PHS booklet entitled "Smoking, Health, and You" stated that the smoke from other people's cigarettes "may make your eyes tear or may make you cough, but it cannot harm you...."

24.

The next report to Congress on smoking and health, the 1972 edition, for the first time cited reports indicating that ambient tobacco smoke could be harmful to nonsmokers. The evidence was not convincing and strong contrary evidence was omitted.

25.

Anti-smoking groups have repeated Dr. Steinfeld's claims in forums throughout the United States and have expanded them to include assertions about a variety of potential injuries to nonsmokers from exposure to ambient tobacco smoke.

26.

The anti-smokers' claims that nonsmokers can be injured by ambient tobacco smoke are not supported by scientific evidence. It is instructive to examine a few of these claims in the light of scientific and medical knowledge.

27.

Toxic substances: Anti-smokers often present a list of so-called "toxic" substances in tobacco smoke as proof that ambient tobacco smoke can be harmful to the nonsmoker.

28.

For example, cigarette smoke contains hydrogen cyanide. Anti-smokers may also say that ambient tobacco smoke includes "side stream" smoke (the smoke which goes directly into the air from the burning end of the cigarette) which has higher concentrations of some substances than the smoke inhaled by the smoker.

29.

These charges ignore the fact that first, the concentrations of these substances in ambient tobacco smoke are minute and, second, these substances are readily diffused in the air.

30.

Allergy: Anti-smokers often complain that many nonsmokers are allergic to tobacco smoke. ASH, for example, asserted in a recent submission to the Civil Aeronautics Board that as many as 30 to 34 million Americans "have a particular sensitivity to tobacco smoke."

31.

There is genuine question whether tobacco smoke has been shown to be or contain an allergen. Dr. Domingo Aviado, Professor of Pharmacology at the University of Pennsylvania Medical School and an internationally recognized expert, made the following statements:

32.

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...should a true tobacco smoke allergy be shown to exist, which has not been done, it would be quite rare. Estimates that large numbers of persons are allergic to tobacco smoke are unsupported by scientific data.

The method of determining whether an allergy exists has not been settled although many allergists make use of a skin test using tobacco leaf extract. Such skin testing is not at all comparable to exposure to tobacco smoke.

There is a major scientific difference between an allergy and an annoyance or an irritation. Individuals may be irritated or annoyed by a wide variety of airborne substances but not necessarily allergic to them.

What about asthmatics? There is no objective scientific evidence to support the claim that ambient cigarette smoke adversely affects the lung function of asthmatics. In a 1977 study by Pinn, Shephard and Silverman, asthmatics were exposed to cigarette smoke in a small test chamber. The researchers were unable to find any significant changes in their lung functions.

Carbon Monoxide: Another claim is that the carbon monoxide in tobacco smoke is poisonous, severely affects a person's "test performance" and can cause cardiovascular and respiratory diseases.

• Numerous studies have shown that carbon monoxide concentrations in enclosed areas resulting from cigarette smoking are very low and do not present an inhalation hazard to the nonsmoker. These studies include actual carbon monoxide measurements and studies of the physical reactions of non-smokers (e.g., Harke 1972).

Auto exhaust and industrial fumes are, by far, the major sources of carbon monoxide in the daily environment.

To support the claim that smoking can produce higher carbon monoxide concentrations, anti-smokers have cited a study involving smoking in an automobile. However, the volume of the car involved was only 73.8 cubic feet, which is equivalent to a cube with sides of 4.2 feet each, and all windows and vents were closed.

In 1977, the FAA considered a petition by anti-smoking groups requesting a rule prohibiting tobacco smoking on the flight deck. The contention was that exposure to relatively low levels of carbon monoxide causes substantial impairments to vital brain and nervous system functions. The FAA carefully considered several studies and ruled that the petition did not disclose adequate reasons to justify the rule it requested.

33.

34.

35.

36.

37.

38.

39.

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It is interesting to note a few carbon monoxide equivalents. One automobile driven 12 1/2 miles emits more carbon monoxide than a 1.4-pack-per-day smoker contributes to the atmosphere in an entire year. A Washington, D.C., Counsel of Governments study found that cars and trucks account for 92 percent of the carbon monoxide released into that region's air. The FAA measurements of carbon monoxide emissions from one Boeing 707 in its 33 minute landing-takeoff cycle is 202 pounds, the same amount as emitted from smoking 1.3 million cigarettes.

Nicotine: In 1975, two Harvard investigators, Hinds and First, measured the concentrations of nicotine in public places in Boston, such as restaurants and cocktail lounges. They demonstrated that in "public places nonsmokers could potentially consume 1/1,000 to 1/100 of one filter cigarette per hour, a level of exposure that has had no known serious association with disease."

In other words, for a nonsmoker to inhale the equivalent of one filter cigarette from ambient tobacco smoke he would have to spend from 100 to 1,000 continuous hours in a smoke-filled bar.

Nonsmokers With Compromised Health: Anti-smokers often argue that exposure to tobacco smoke causes stress to persons with severely compromised cardiovascular systems.

Because a delicate condition is presumed, it is impossible to establish a "no effect" level of carbon monoxide exposure for these persons, and there is some evidence that they may be adversely affected to some degree by any exposure sufficient to raise the carbon monoxide blood level.

This situation is indeed unfortunate. However, reference to this category of people as a reason for prohibiting smoking in public places ignores the fact that they may be subjected to discomfort and stress in the course of their normal daily encounters with carbon monoxide from automobile exhaust fumes and other air pollution. It has been stated that the only adequate protection for these persons would be to maintain them in an "oxygen-enriched" environment.

THE NON-PROBLEM

A study of cigarette smoking in aircraft conducted jointly by HEW, the FAA and the Department of Transportation concluded that the inhalation of ambient tobacco smoke aboard commercial aircraft "does not represent a significant health hazard to nonsmoking passengers." The result of the study was first announced in 1970, prior to the time of Surgeon General Steinfeld's statement that evidence showed ambient tobacco smoke could be harmful to nonsmokers.

40.

41.

42.

43.

44.

45.

46.

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The ICC held extensive hearings in 1970 on smoking in buses. Although the ICC decided to segregate smokers on the basis of annoyance, it found that the asserted deleterious effects of second-hand smoke upon the health of motor bus passengers had not been adequately demonstrated.

47.

Dr. Edwin R. Fisher, Professor of Pathology at the University of Pittsburgh and Director of Laboratories at the Shadyside Hospital in Pittsburgh, said in October, 1977 that a careful review of research literature failed to support the conclusion that ambient tobacco smoke represented a health hazard to nonsmokers. Dr. Fisher said:

48.

The few studies that might appear to be contrary to this conclusion can, in my view, be rather readily dismissed for reasons of improper experimental design and lack of practical significance. For example, some studies use unrealistic quantities of smoke or fail to consider other sources of the agents being studied.

Even several eminent researchers and government officials who are well known for their opposition to tobacco use agree that public smoking is not harmful. Dr. Gio Gori of the National Cancer Institute said, "If we want to remain with facts and not with fiction, there is little danger of disease to people that stay in a room where people smoke."

49.

Dr. Reginald Stallones, an advisor to the Surgeon General's Advisory Committee on Smoking and Health, recently said, "In very direct terms there is no medical proof that non-smokers exposed to cigarette smoke in ordinary relation with smokers suffer any damage."

50.

Dr. E. C. Hammond, vice president, Epidemiology and Statistical Research, of the American Cancer Society and author of famous studies linking smoking and lung cancer, was reported to have made statements to the International Conference on Public Education About Cancer in 1974 as follows:

51.

Dr. Hammond stated that there was "no shred of evidence that a non-smoker can get cancer from 'second hand' smoke and there is a lot of evidence that he cannot...." He added that to suggest passive smoking (inhalation of smoke by non-smokers) could cause cancer is dishonest, and that he would be prepared to testify as such in court.

It is apparent that anti-smokers' claims that nonsmokers are subject to injury by ambient tobacco smoke are not supported by scientific evidence.

52.

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Produced by R. J. R. T. C.

CHECKLIST OF ARGUMENTS

The following suggestions are intended to be guides for writing or speaking in response to anti-smoking arguments on public smoking actions. It is important to remember that health or scientific arguments can be ineffective in communicating with the general public. On the other hand, most people can clearly identify with arguments based on freedom of choice, and many people feel strongly that the "hand of government" should not interfere with their private lives.

53.

Restricting smoking in business establishments should be up to the proprietor.

54.

Every restaurant, hotel, and other public establishment is presently free to establish no smoking areas if this is the desire of patrons. It should be the proprietor's choice based on customer demand and "the marketplace."

The fact is that a majority of public establishments do not have no smoking sections. A survey by the National Restaurant Association confirmed that few members of the public actually desire separate sections for smokers and nonsmokers.

"The public smoking issue" can be resolved on the basis of common courtesy.

55.

- Most smokers will show respect for the wishes of those around them.

Public smoking laws present grave enforcement problems.

56.

During the prohibition era this country learned of the great difficulty government has in enforcing matters of social morality and conduct. Unless the police go on rounds to arrest an individual as soon as the person lights up in a no smoking area, it will be practically impossible to enforce public smoking laws effectively.

To the extent that shop owners and other proprietors are expected to be enforcers of these laws, they will be subject to difficult dilemmas. If a smoker lights up in a no smoking section, can the owner of a restaurant ask the person to extinguish the cigarette without risking the loss of patronage?

In light of serious U.S. crime problems, it is foolish to take police away from critical duties to determine whether a cigarette has been lighted in a no smoking zone. Yet if such laws are not

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Produced by RTRC

vigorously enforced, their flagrant violation can breed further disrespect for the law.

How can anyone justify the cost of enforcing public smoking laws?

57.

Taxpayers are usually not aware of the high cost of restrictive ordinances. For example, it was reported that a San Diego public smoking ordinance cost taxpayers \$20,000 merely to get the law on the books in January, 1975. Complaints to the Police Department there cost over \$70 each for the officer's time, processing, paper work and court action.

Public smoking laws will place a substantial burden on individual proprietors and on the economy.

58.

This is particularly true when public smoking laws require the erection of physical barricades, improvements of the air circulation system, and other capital expenditures. The costs of compliance with such laws can be substantial. In addition, many establishments may be so small that they cannot effectively segregate smokers and nonsmokers.

A restaurant's economic success depends on maximum peak-hour traffic. Restricting the use of a small area at that time can cause losses. Customers also can become irritated. For example, a smoker arriving to find a line waiting for the smoking section, when the no smoking section is empty, may be understandably angry. Whenever a patron is turned away, the proprietor risks losing that customer's business forever.

Efforts to attract conventions would be dampened by the risk that conventioners could be fined or jailed for lighting up in the wrong location.

Should an individual's smoking in public be criminally restricted by government actions?

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Is jail really the appropriate place for an individual whose "crime" is lighting a cigarette?

How far will government go to restrict our private lives?

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There are obviously many public annoyances to everyone in their daily lives. The "bad" or conflicting behavior and manners of other people in public places can cause substantial

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irritation. The noise and fumes of heavy traffic, the dissatisfaction toward public services like sanitation and law enforcement, the irritation from dirty streets, barking dogs, noisy neighbors or even the weather can certainly be more severe than the diffused smell of tobacco smoke in a ventilated public place.

Should laws also be passed to ensure good manners and behavior, and, if so, by whose standards? Any effort to extend government regulation into these areas would result in a massive interference with an individual's personal life and freedoms.

The public smoking issue may be best summarized by an editorial appearing in the Boulder Camera, (Boulder, Colorado, January 22, 1975):

It's one thing to legislate conduct for the protection of society--to restrict behavior that endangers the life, health or safety of others. It is quite another to legislate against conduct that merely annoys. Hardly anybody can avoid annoying somebody else occasionally. When government gets one foot into the realm of behavior modification, the blue-law thicket looms ahead.

Smokers' wishes should be respected, too.

The question of segregating smokers is really a matter of balancing the convenience and preference of smokers and nonsmokers. Although nonsmokers certainly have interests that must be considered, smokers also should be accommodated. The best and most effective method of balancing those desires and interests is through common courtesy on both sides, without the imposition of rigid and unworkable government requirements.

This nation does itself no service when unnecessary social conflict arises from the advocacy of misstated and erroneous health concerns.

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QUESTIONS & ANSWERS

Individuals associated with the tobacco industry often are confronted by thought-provoking questions regarding smoking and health, public smoking and other issues which make up the controversy surrounding the industry. In the past, employees have not been adequately equipped to deal with these questions. Brown & Williamson prepared this handbook in an effort to inform employees with a depth of knowledge surrounding the issues.

The following section includes a series of questions and answers covering a variety of issues. These questions have been accumulated from media interviews and discussions with a variety of groups by Brown & Williamson and industry spokespersons. The following questions and answers are not intended to make "spokespersons" out of Brown & Williamson employees, but they are intended to better inform our managers.

Q: Does smoking cause lung cancer, emphysema, cardiovascular disease and bronchitis?

A: No one knows. Scientific research has not established that smoking causes illness. We all know some scientists have said smoking causes illness, but many respected scientists believe cause has not been shown. More research is needed.

Q: How can you deny the overwhelming statistical evidence that smoking causes disease?

A: The case against smoking is based almost entirely on inferences from statistics. But most scientists will agree that statistical associations cannot establish cause and effect. Statistical associations are only clues which show the need for clinical and laboratory experiments. There are other flaws in the statistical arguments, such as the reliability of the data. By the way, there is a statistical association between lung cancer and the use of electric razors. We need more biological research.

Q: When you look at lungs taken from smokers and nonsmokers, it's obvious that smoking has damaged the lungs of the smoker, as compared to the lungs of the nonsmoker. This proves that smokers are damaging their lungs.

A: Perhaps you've seen the rather grisly exhibit set up by the American Cancer Society which contains two specimens of lung tissue, one which is smooth with a light cream color and the other which has warts and is coal black. One lung is said to be from a smoker and the other from a nonsmoker. You can guess which is which. The exhibit is deceptive because it represents that the differences in the tissues are typical results of smoking. This is not true. A former president of the College of American

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Pathologists testified before a Congressional Committee that: "I have examined thousands of lungs both grossly and microscopically. I cannot tell you from examining a lung whether or not its former host had smoked....I state flatly and unequivocally and emphatically that cigarette smoking will not turn the lung black."

Q: Do you deny that smoking is hazardous to your health?

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A: No one knows. Many respected scientists believe that a causal relationship between cigarette smoking and illness has not been proven.

Q: Do you claim that the benefits of smoking outweigh the risks?

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A: Whether or not to smoke is a choice to be made by informed adults based on individual assessments. Obviously many people derive some value from smoking because it has been a popular custom for hundreds of years. Columbus found the American Indians smoking, and sales of tobacco leaf supported the Jamestown Colony.

Q: How can you smoke when you know you are causing health problems to nonsmokers in the same room?

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A: Smoke in the ambient air is not harmful to the health of the nonsmoker. Even medical experts who have been associated with the charge that smoking causes lung cancer in the smoker have said that smoke in the ambient air has no influence on the health of the nonsmoker.

Q: Why are manufacturers producing more low "tar" and nicotine cigarettes and advertising those brands heavily if there is no health risk involved in smoking high "tar" and nicotine cigarettes?

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A: Cigarette manufacturers are producing low "tar" and nicotine cigarettes in response to consumer demands for those products. Their perception of the growth of the low "tar" segment is correct. Sales of cigarettes with less than 15 milligrams "tar" content increased by more than 50 percent in 1976 and comprised roughly 25 percent of the total cigarette market in 1977. Only a few years ago low "tar" and nicotine cigarettes were an insignificant part of the market. This very rapid shift shows the cigarette manufacturers' eagerness to respond to customers' changing preferences. The advertising emphasis simply follows the shift in consumer demand. No cigarette manufacturer has said there is no health risk involved in smoking high "tar" and nicotine brands. As with the question of smoking and disease in general, no one knows.

Q: How much money does the tobacco industry spend each year in advertising to attract new smokers?

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A: None. Cigarette advertising is brand advertising. Its purpose is competition against other brands for consumers, not to attract new smokers.

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- Q: Nine out of ten smokers say they want to quit. Shouldn't the government help them by sponsoring quit-smoking programs?
- A: Each adult individual must make up his own mind whether to smoke. The tobacco industry is not interested in preventing anyone from giving up cigarettes. Many private stop-smoking programs are available at little cost, and literature which describes ways to stop smoking is available from several sources. Many people have stopped without a formal program. It is not necessary to spend taxpayers' money.
- Q: Doesn't the cigarette industry feel some responsibility for the \$8 billion cost to the United States for health care and \$18 billion cost to the United States in loss of production time caused by cigarettes sold?
- A: The charge is based on the assumption that smoking causes illness; but causation has not been established by scientific research. There are other difficulties with the figures. For example, the figures assume the need for health services included would disappear if no one smoked cigarettes. With our aging population, this is unlikely.
- Q: Doesn't the nonsmoking majority in this country have the right to vote that cigarettes should not be smoked in public places?
- A: No! Such a law would be completely unjustified as a function of government in our society. Tolerance is the cornerstone of this country's democracy. There is no health danger to nonsmokers -- the problem is annoyance. This is a social matter which must be left to people to resolve in social situations through mutual courtesy. Laws dictating personal social conduct, arrests, fines, and forced segregation are inappropriate means of dealing with a social situation. If there are going to be laws prohibiting smoking in public places, there should certainly be laws prohibiting strong perfume, body odor, and untrained pets.
- Q: What would you tell your child if he asked you whether he should smoke cigarettes?
- A: I would tell him to wait until he was an adult and then make up his own mind. Whether to smoke is a choice for the individual and a choice that should be made only by informed adults.
- Q: How do you account for the fact that so many government and scientific societies have passed resolutions asserting that smoking causes lung cancer and other human diseases?

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A: The fact that government bodies and scientific societies have passed such resolutions indicates that the continuing controversy over smoking and health is political, not scientific. Scientific issues in the medical field are settled by definitive biological experimentation, not by the passage of a resolution. There have been no experiments proving that cigarette smoking causes illness, and that is why activists in government agencies and scientific organizations have resorted to resolutions to establish their personal opinions.

Q: Don't all of the medical experts in the United States agree that smoking causes lung cancer?

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A: As a matter of fact, many scientists in the United States hold the view that smoking has not been scientifically established as a cause of lung cancer. They note that no one knows the cause or causes of lung cancer. Nor does anyone know the mechanism or mechanisms whereby this disease develops.

Q: Won't you concede that smoking is a prime suspect as a cause of lung cancer?

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A: Scientists generally agree that lung cancer is a multifactorial disease, i.e., it has been statistically associated with many factors. These include occupation, geographical location, sex, urbanization and several others as well as smoking. But factor does not mean cause. Whether any of these suspects plays a role in the causation of this disease is as yet unknown.

Q: Aren't there cancer-causing agents in tobacco smoke? Don't they explain the association between smoking and lung cancer?

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A: For more than 20 years now, cancer researchers have been trying to identify components in tobacco smoke that are harmful to human health. To date, however, they have not identified any ingredient or group of ingredients, as found in tobacco smoke, that are disease-producing in humans.

Q: Doesn't tobacco "tar" produce cancer in animals?

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A: Contrary to popular belief, human smokers are not exposed to tobacco smoke condensate -- commonly referred to as "tar." Tobacco "tar" is a laboratory product that is produced by passing tobacco smoke through a cold trap at an extremely low temperature -- a temperature that human smokers simply do not experience. Hence, the relevance of animal experiments with tobacco "tar" is dubious. And it should be remembered that, despite great efforts by many scientists, human-type lung cancers have not been produced in laboratory animals as a result of exposure to tobacco smoke.

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should be classified as habituating, like coffee, and not addictive, like morphine. Many people have given up smoking. Why do some people continue to smoke who say they want to quit? Why do people continue to overeat when they say they are too fat?

Q: Isn't modern cigarette advertising an improper business practice because it has a heavy impact on children and leads them to smoke?

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A: Cigarette advertising is intended for adults only. For example, cigarette advertisements show no models who are under 25 years of age, no entertainment celebrities and no athletes. Cigarette advertising can establish brand loyalty -- and that is its purpose -- but it does not attract new smokers. No studies have shown that cigarette advertising causes children to smoke. Dr. Ernest L. Wynder, president of The American Health Foundation, said he did not believe cigarette advertising had much influence on smoking.

Q: What questions were left unanswered by the 1964 Surgeon General's Report?

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A: Many questions were left unresolved. Why, for example, do nonsmokers fall victim to heart disease, lung cancer and other diseases frequently associated with smokers? If, as some anti-smoking groups claim, cigarette smoking is the major cause of lung cancer, why is it that the vast majority of the "heavy" smokers never develop the disease? Why hasn't independent scientific research been able to identify any one or combination of the thousands of components as found in cigarette smoke as the cause of any particular disease? Why in more than forty years of research hasn't anyone been able to reproduce the type of lung cancer associated with smoking--through tobacco smoke inhalation--in laboratory animals?

Q: Will the anti-smoking movement succeed?

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A: The anti-smoking movement is actually proposing prohibition. According to Dr. Peter Bourne, Special Assistant to the President for Health Issues, such proposals are not realistic. In remarks to the Ad Hoc Committee on Tobacco and Smoking Research of the American Cancer Society on November 10, 1977, Dr. Bourne said, "Because of the political, social and economic ramifications, it is unrealistic for us to suggest a tobacco prohibition as a feasible short-term goal, and that campaign would bring into question our own credibility. It is there that we are on our weakest ground. While prohibiting use of cigarettes in public places would please nonsmokers, it would not necessarily reduce overall cigarette consumption or reduce the health consequences. We have done little research on the hazards, if any, of other people's cigarettes."

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- Q: What is the tobacco industry doing to help resolve the smoking and health controversy?
- A: In the last 24 years the tobacco industry has provided more than \$70 million for independent research regarding questions related to smoking and health. In many of these years this commitment has exceeded that of any government department, and has been substantially more than the research expenditure reported by all the voluntary health associations, who spend a major portion of their donated funds for administration and for public relations campaigns. The tobacco industry is committed to advancing scientific inquiry in this area.
- Q: Do the tobacco companies control the research they sponsor?
- A: Absolutely not! The commitment of the tobacco manufacturers to resolve the smoking and health controversy has never been fully appreciated. Grants are made with no strings attached except a pledge to apply the money to legitimate scientific research. Each researcher is free to publish his study results, whatever they may be.
- Q: Does it bother your conscience to sell cigarettes?
- A: Absolutely not! The tobacco industry is a \$15 billion industry affecting 17 million people. As far as the health question is concerned, no valid research has ever established that cigarette smoking causes illness. Nevertheless, every pack of cigarettes carries a warning label as required by law. A person would have to be a "cave dweller" not to be aware of the warning. We live and work in a country which supports the free enterprise system. It gives its citizens the freedom of choice. We should continue to enjoy that freedom both in our business and in our personal lives.

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THE OPEN QUESTION

For many years, certain individuals and organizations have claimed that smoking causes a large number of diseases. Such claims are largely based on studies which have reported statistical associations between smoking and various diseases.

However, such associations alone can never establish cause-and-effect relationships. The most that such data can do is to indicate areas for further scientific research. Unfortunately, scientific data that contradict the popularly-held belief that smoking causes disease are generally ignored or severely criticized without adequate justification.

It has become easier to indict smoking as the sole source of our medical problems than to confront the data which show an existing scientific controversy and the need for further well-defined objective research to establish the facts. The following discussion will highlight some of the topics mentioned above.

SMOKING AND LUNG CANCER

The evidence cited to implicate cigarette smoking as a cause of lung cancer has been provided primarily by statistical studies, such as the Hammond and Horn survey of white American men in nine states. However, such studies have been seriously questioned. For example, in 1958, Dr. Joseph Berkson of Mayo Clinic observed that "Cancer is a biologic, not a statistical, problem." More recently, a British physician noted that "the cause of cancer of the lung is not known. We have only statistical inferences and forecasts.... Until it is discovered no one who values scientific evidence should assume that cigarettes cause cancer of the lung."

In 1977, a South African physician who reviewed some of the original statistical studies which are used to support the claim of a causal relationship discovered errors in the analyses of the data. As a result of these discoveries and other observations, he concluded that "The smoking hypothesis has received emphasis which it really does not deserve." He added that "This hypothesis has to be abandoned."

One of the most pertinent facts to be kept in mind when claims about smoking and lung cancer are considered is that some reported statistical data are not consistent with the causal hypothesis. For example, researchers have reported large variations in lung cancer mortality rates in a number of countries which cannot be explained by differences in

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tobacco consumption. Austria, Belgium and Finland report higher lung cancer rates but considerably lower per capita tobacco consumption than the United States, Canada and Australia.

Lung cancer mortality rates may not be reliable because they are based on the often inaccurate information regarding cause of death as shown on death certificates. This conclusion is supported by the finding of researchers who compared clinicians' diagnoses of lung cancer with autopsy results and found serious discrepancies. Such errors may have resulted in part from the clinicians' difficulties in determining whether a cancer originated in the lung or had spread to the lung from another site.

The reported increase in lung cancer, said to be of "epidemic" proportions, may be greatly overestimated. Experts have suggested that the reported increase may be an artifact created largely by improved diagnostic techniques. The recent intense interest in lung cancer may also have resulted in an over-diagnosis of the disease.

Experiments in which laboratory animals are forced to inhale tobacco smoke have failed to prove the hypothesis that smoking causes lung cancer. Not only has the relevance of such experiments been questioned, these techniques have failed to produce in animals any lung tumors which are of the type associated with human smoking.

Much of the interest in the causation theory was generated by skin-painting experiments in which tumors were produced by painting "tar" (a laboratory product obtained by passing tobacco smoke through a cold trap at extremely low temperatures) on the shaved backs of animals. However, these experiments are inappropriate for comparison to the inhalation process of humans, for several reasons. The skin of an animal is not at all similar to human lung tissue. Furthermore, the application of a substance to the skin is quite different from inhalation. Finally, there is no "tar" as such in tobacco smoke, and even if there were, the quantities used in such experiments are unrealistic.

In an effort to determine why some people develop lung cancer while others do not, a number of scientists are studying the "constitutional hypothesis." This hypothesis states that some people who have a hereditary predisposition for lung cancer also have a hereditary tendency towards smoking. It is supported by research which shows that smokers differ from non-smokers in many physiological and psychological characteristics.

Occupational and environmental factors, such as air pollution, have also been found to be associated with lung cancer. Concern has been expressed that the concerted effort

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to prove that smoking is the primary cause of this disease may be diverting attention from such factors.

Any serious discussion of the claims linking smoking and lung cancer must include consideration of the following two facts:

1. Lung cancer was an established disease long before cigarette usage became popular.
2. Most smokers do not develop lung cancer, while many non-smokers do.

SMOKING AND CORONARY HEART DISEASE (CHD)

In efforts to determine the cause of coronary heart disease, researchers have examined a variety of behavioral, physiological and environmental factors which have been associated with an increased risk of this disease. Cigarette smoking is considered by some to be one of these so-called "risk factors."

For example, the 1976 Public Health Service Report on The Health Consequences of Smoking describes smoking as "one of the major independent CHD risk factors." However, available data ~~do not~~ provide consistent support for the identification of smoking as a risk factor. For example, an international study by Keys found "little or no" relationship between cigarette smoking and coronary heart disease in Finland, the Netherlands, Yugoslavia, Italy, Greece and Japan. Furthermore, several studies cited to support the role of smoking in the development of coronary heart disease contain data inconsistent with this claim. In one such study, coronary heart disease mortality rates actually were lower in ex-smokers than in nonsmokers.

Researchers also have studied a number of other factors which appear to be associated with an increased prevalence of this disease. For example, some scientists have observed specific behavior patterns that appear to be associated with an increased prevalence of CHD. This coronary-prone behavior pattern, called Type A, is characterized by such traits as aggressiveness, ambitiousness, time consciousness, and a chronic sense of urgency. Other scientists have concluded that there is a strong genetic component in the development of CHD. Studies of twins and familial coronary heart disease patterns have provided support for this theory.

The stresses normally encountered in daily life also have been positively associated with coronary heart disease. Researchers have found that severe financial problems, occupational tensions, and life-style changes have produced physiological alterations which may lead to coronary lesions. One

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investigator, who studied the mortality statistics of 100,000 physicians who reportedly had quit smoking, commented:

It is evident that there has been no increase in the average age of death among physicians during the past 16 years. . . . While it is possible that the full results of this abstinence (not smoking) have not yet been seen, the resolution of underlying stress rather than smoking per se may be the crucial factor. . . . These findings are consistent with the apparent predisposition of doctors to coronary heart disease, a vulnerability which can be attributed to the stresses in their way of life.

Therefore, the indictment of cigarette smoking as a major risk factor in coronary heart disease mortality is contradictory to such scientific fact.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Claims have been made that cigarette smoking causes COPD, a term which refers primarily to chronic bronchitis and pulmonary emphysema. Such a claim was made in the most recent report on smoking by the Royal College of Physicians of London called "Smoking or Health."

However, these claims are contradicted by statements of scientists and governmental officials who note that the cause or causes of these chronic lung diseases are still unknown. For example, a special report supplied by the Department of Health, Education and Welfare for use during consideration of its 1979 budget request indicates that "the exact cause of emphysema is not known"

Such statements are supported by an examination of cigarette consumption patterns which exhibit no consistent relationship with COPD incidence rates and mortality trends. This is illustrated by the fact that individuals who have never smoked develop COPD but many smokers do not. Moreover, large international variations in COPD mortality rates cannot be explained by levels of tobacco use.

Certain animal inhalation studies have been cited as proof that smoking causes COPD. However, serious questions have been raised about the adequacy of the experimental techniques employed and the relevance of the results to man. For example, numerous structural differences identified in the respiratory systems of mammals may complicate the extrapolation of animal test results to the human situation.

Some researchers who have examined the reported increase of COPD in cigarette smokers speculate that it may be

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the result of basic psychological and/or physiological differences between smokers and nonsmokers. For example, even when smoking habits are similar, blacks seem to have a lower incidence of chronic bronchitis and emphysema than whites.

Occupational exposures may also play an important role in the development of COPD. A scientist familiar with occupational exposures recently wrote that the available evidence does not support claims that smoking is the major hazard to workers' lungs; he concluded, "... it's their jobs which seem to cause their illness."

In recent years, ambient air pollution has received increasing attention as a major cause of COPD. Lave and Seskin have concluded that "mortality from bronchitis would be reduced by about 50% if air pollution were lowered to levels currently prevailing in urban areas with relatively clean air." They continue:

The studies document a strong relationship between all respiratory disease and air pollution. It seems likely that 25% of all morbidity and mortality due to respiratory disease could be saved by a 50% abatement in air pollution levels.

Therefore, claims that smoking causes COPD must be seriously considered in light of this evidence.

SMOKING AND PREGNANCY

Claims have been made that smoking during pregnancy causes adverse effects, in particular that smokers are more likely to have low-birth-weight (LBW) infants. Some claims have even been made that smoking increases the risk of congenital malformation and perinatal mortality. However, these claims are based on statistical data which are at best equivocal and, furthermore, cannot prove causal relationships. Moreover, there are data which are inconsistent with certain of these claims.

Low-Birth-Weight Infants. A biostatistician who examined and was unable to accept the causal hypothesis contended that the data he studied may suggest the existence of some other common factor which causes women both to smoke and to have a higher proportion of LBW infants. Yerushalmy advanced this theory in a 1972 report describing data which, he later said, "almost clinch the argument against causation:"

This conclusion follows from the finding that women who eventually became smokers produced a large proportion of low birth weight infants even before they started to smoke. . . .

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To explain these findings, Yerushalmy speculated that the higher incidence of LBW infants among smoking women may be due to the smoker, rather than the smoking.

Yerushalmy's findings are supported by the results of other research projects, including two studies in which the researchers concluded that smoking apparently does not cause LBW but may serve as "an indicator" or "an index" of some other factor or factors that may be involved.

The need for further research on the relationship between maternal smoking and LBW was recognized by Silverman in a report on her study which had been designed to determine whether smoking causes LBW, or whether smokers are "a self-selected group that differs from nonsmokers in ways unrelated to smoking. . . ." Although she wrote that her findings were not conclusive, she observed that "The direction of the observed differences in mean birth weights is more consistent with the self-selection hypothesis."

Although these studies have failed to disprove either the causal or self-selection hypotheses, several have shown that smokers' LBW infants appear to be healthier than non-smokers'. Yerushalmy, for example, noted that LBW infants of smokers "are much healthier" than those of the nonsmokers and that the "healthiest" low-weight babies were born to couples in which the wife smoked and the husband did not.

Increased Perinatal Mortality. Scientific evidence does not support the claim that maternal smoking during pregnancy is causally associated with increased perinatal mortality. Several large studies, including those by Yerushalmy, Underwood, The Ontario Perinatal Mortality Study Committee, Rantakallio, and Targett have found no increase in the perinatal mortality rate of infants of smoking mothers. As the National Academy of Sciences Committee on Maternal Nutrition concluded in 1970, ". . . smoking is not significantly associated with excess fetal or neonatal mortality. . . ."

Congenital Malformation. Several large-scale population studies also have failed to establish a relationship between smoking and congenital malformation.

In a study of 51,490 pregnancies, for example, the Ontario Perinatal Mortality Study Commission found "no evidence that smoking was associated with a higher incidence of congenital malformations." Yerushalmy and Hollingsworth both reported that their studies showed that the risk of congenital malformation in LBW infants was lower for smoking than for nonsmoking mothers.

The available scientific evidence does not warrant the conclusion that a causal relationship between smoking, LBW, increased perinatal mortality and congenital malformation has been proven.

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CIGARETTE SMOKE COMPONENTS

Despite much repetition of the claim that certain substances in tobacco smoke are harmful to the smoker, it has not been scientifically proven that any component or combination of components as found in tobacco smoke causes disease.

These claims, which focus primarily on "tar," nicotine and carbon monoxide (CO), have led to proposals for establishing maximum levels of such substances in tobacco smoke. Such a recommendation currently is being considered by the Department of Health, Education and Welfare as part of a major anti-smoking initiative launched by Secretary Joseph Califano.

The following discussion describes some of the inadequacies of the scientific evidence for the claimed health effects of these three substances.

"Tar." There is no "tar" as such in cigarette smoke. The substance called "tar" is actually a laboratory product obtained by collecting the particulate matter in tobacco smoke. This hardly simulates what humans are exposed to in the smoking process. That is why quotation marks are often used around the word "tar" when referring to tobacco smoke.

"Tar" is not smoke. There is no good reason to assume that any biological activity of whole smoke can be accurately determined by studying "tar." The chemical and physical changes necessarily brought about in condensing the smoke and applying the substance to animals may well produce biological results completely different from any that may occur during smoke inhalation.

Nicotine. Nicotine has historically received as much experimental attention as "tar." However, nicotine, in the amounts found in tobacco smoke, has not been scientifically established as hazardous to smokers. Even the 1964 Report to the Surgeon General on Smoking and Health concluded that nicotine as found in tobacco smoke "probably does not represent a significant health problem." After thirteen years of intensive research, no data have been developed which would warrant a change in that conclusion.

Nicotine has no known chronic or cumulative effects. It is rapidly absorbed and metabolized by the human body into other simpler substances which exhibit no established harmful pharmacological activity. According to the 1964 Report to the Surgeon General, "Nicotine is rapidly changed in the body to relatively inactive substances with low toxicity."

Despite these statements, some smoking opponents have claimed that nicotine causes cardiovascular disease. However,

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this claim was clearly contradicted in testimony by a government witness at the 1976 hearings on cigarette smoking and disease. Dr. Theodore Cooper, then Assistant Secretary for Health, Department of Health, Education and Welfare, indicated that he considered smoking a risk factor for cardiovascular disease, but not a cause:

Senator Hart: ...I would merely ask if cigarette smoking causes heart disease?

Dr. Cooper: No.

Senator Hart: It does not?

Dr. Cooper: No.

Carbon Monoxide. This tasteless, odorless gas is present in tobacco smoke, but it is also present in the air we breathe. The predominant man-made sources include the exhaust fumes of automobiles and emissions from industrial processes. Furthermore, carbon monoxide is a natural body constituent created by normal metabolism.

As with tar and nicotine, the experimental evidence regarding adverse health effects of CO, as found in cigarette smoke, is at best inconsistent. Studies of humans who are consistently exposed to low doses of CO have reported no increase in the incidence of heart attack or circulatory abnormalities.

Possibly because experiments with humans have failed to prove their claims, anti-smoking advocates have emphasized the results of animal experiments by certain researchers. Yet when animal experimentation is examined as a whole, it also fails to provide consistent results on the effects of CO exposure. Moreover, the recent research findings of one of the scientists frequently cited as having demonstrated a link between carbon monoxide and heart disease did not confirm the conclusions about the effects of carbon monoxide drawn in his earlier studies.

Such evidence indicates that the claims made about the health effects of certain constituents of tobacco smoke on the smoker are just that--claims which are not established by scientific proof.

RESEARCH

The scientific commitment of the tobacco industry is clear. For nearly 25 years the cigarette manufacturers have been supporting totally independent research with completely non-restrictive funding. The results--whatever they are--may be published wherever the researcher chooses.

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Hundreds of researchers in medical schools, hospitals and other scientific institutions in this country and abroad have received more than \$70 million from the tobacco industry to support their investigations.

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The findings of scientific studies funded in whole or part by the cigarette companies comprise more than 2,000 papers published in the world's professional literature.

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The Council for Tobacco Research - U.S.A., Inc., an industry-sponsored agency, has the major responsibility for the evaluation and funding of research proposals. Research support has been implemented mainly through a program of grants-in-aid, supplemented by contracts for research with institutions and laboratories. The Council does not operate a research facility.

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The position of the tobacco industry is that the questions raised by the smoking and health controversy can be resolved only by sound scientific research.

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MOTIVES AND INCENTIVES IN CIGARETTE SMOKING

William L. Dunn, Jr.
Philip Morris Research Center
Richmond, Virginia

PLAINTIFF'S
EXHIBIT

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There is a lovely little island lying about 150 miles east of the Virgin Islands. It is at the northern end of the Antilles, that string of islands flung out crescent-like across the blue Caribbean waters. Legend has it that in the 16th century, both the Dutch and the French lay claim to possession of this tiny body of land. Rather than fight it out as was their wont in those days they showed a surprising and exemplary willingness to apply human reason. A Frenchman and a Dutchman were placed back to back on the beach and told to walk along the beach until they met again on the opposite side. They did so, and a line was drawn between the points of start and finish, dividing the island into the French half called St. Martin, and the Dutch half called San Marteen.

It seems that the Frenchman walked faster than the Dutchman, because the French got the bigger half. Some say this was because the Frenchman was drinking French champagne and the Dutchman was drinking Dutch whiskey. However true all this may be, the two colonies continue to live peacefully under these 16th century terms.

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In January, 1972, the Dutch side of St. Martin was invaded by an unlikely party of twenty-five scientists. There were pharmacologists, sociologists, anthropologists and a preponderance of psychologists. They came from England, Canada and the United States. Each brought with him a carefully prepared scientific paper which represented his best efforts at attacking the question "Why do people smoke cigarettes?"

Inspired by the rare 16th century display of human reason shown by the French and Dutch colonists, and while not sunning on the beach, they listened to and reflected upon each other's ideas.

You've heard many explanations for cigarette smoking. These were reviewed at the St. Martin conference. I think it appropriate that we list the more commonly proposed explanations here:

- 1) For social acceptance or ego-enhancement
- 2) For pleasure of the senses (taste, smell)
- 3) For oral gratification in the psychoanalytic sense
- 4) A psychomotor habit for the release of body tension
- 5) For the pharmacological effect of smoke constituents.

I might mention one other explanation, not because anybody believes it but as an example of how distorted one's reasoning can become when under the influence of psychoanalytic theory.

Smoking according to this argument, is the consequence of pulmonary eroticism. Translated, this means the lungs have become sexualized and smoking is but another form of the sexual act.

If one asks the smoker himself why he smokes, he is most likely to say "It's a habit." If he is intelligent enough, he might be more to the point and say either one of two things: "It stimulates me", or "It relaxes me". And now we are already deep into our topic. The polarity of these two observations has plagued investigators for fifty years. The challenge to any theory as to why people smoke lies in the theory's ability to resolve this paradoxical duality of effect.

The St. Martin conference was called by the Council for Tobacco Research, U.S.A., in an effort to goad the scientific community into having another go at the problem. And go at it they did. Much of what follows in this presentation comes from that St. Martin conference.

Most of the conferees would agree with this proposition: The primary incentive to cigarette smoking is the immediate salutary effect of inhaled smoke upon body function. This is not to suggest that this effect is the only incentive. Cigarette smoking is so pervasive of life style that it is inevitable that other secondary incentives should become operative. The conference summarizer, Prof. Seymour Kety of Harvard, used eating as an analogy. Elaborate behavioral rituals, taste preferences, and social institutions have been built around the elemental act of eating, to such an extent that we find pleasure in eating even when not hungry.

It would be difficult for any of us to imagine the fate of eating, were there not ever any nutritive gain involved. It would

be even more provocative to speculate about the fate of sex without orgasm. I'd rather not think about it.

As with eating and copulating, so it is with smoking. The physiological effect serves as the primary incentive; all other incentives are secondary.

The majority of the conferees would go even further and accept the proposition that nicotine is the active constituent of cigarette smoke. Without nicotine, the argument goes, there would be no smoking. Some strong evidence can be marshalled to support this argument:

- 1) No one has ever become a cigarette smoker by smoking cigarettes without nicotine.
- 2) Most of the physiological responses to inhaled smoke have been shown to be nicotine-related.
- 3) Despite many low nicotine brand entries into the marketplace, none of them have captured a substantial segment of the market. In fact, critics of the industry would do well to reflect upon the indifference of the consumer to the industry's efforts to sell low-delivery brands. 94% of the cigarettes sold in the U.S. deliver more than 1 mg. of nicotine. 98.5% deliver more than .9 mg. The physiological response to nicotine can readily be elicited by cigarettes delivering in the range of 1 mg. of nicotine.

I hope our English friends who are developing the synthetic nicotineless cigarette are not going to be too disturbed by all this.

Why then is there not a market for nicotine per se, to be eaten, sucked, drunk, injected, inserted or inhaled as a pure aerosol? The answer, and I feel quite strongly about this, is that the cigarette is in fact among the most awe-inspiring examples of the ingenuity of man. Let me explain my conviction.

The cigarette should be conceived not as a product but as a package. The product is nicotine. The cigarette is but one of many package layers. There is the carton, which contains the pack, which contains the cigarette, which contains the smoke. The smoke is the final package. The smoker must strip off all these package layers to get to that which he seeks.

But consider for a moment what 200 years of trial and error designing has brought in the way of nicotine packaging:

Think of the cigarette pack as a storage container for a day's supply of nicotine:

- 1) It is unobtrusively portable.
- 2) Its contents are instantly accessible.

Think of the cigarette as a dispenser for a dose unit of nicotine:

- 1) It is readily prepped for dispensing nicotine
- 2) Its rate of combustion meters the dispensing rate, setting an upper safe limit for a substance that can be toxic in large doses.
- 3) Dispensing is unobtrusive to most ongoing behavior.

Think of a puff of smoke as the vehicle of nicotine:

- 1) A convenient 35 cc mouthful contains approximately the right amount of nicotine.
- 2) The smoker has wide latitude in further calibration: puff volume, puff interval, depth and duration of inhalation. We have recorded wide variability in intake among smokers. Among a group of pack-a-day smokers, some will take in less than the average half-pack smoker, some will take in more than the average two-pack-a-day smoker.
- 3) Highly absorbable: 97% nicotine retention.
- 4) Rapid transfer: nicotine delivered to blood stream in 1 to 3 minutes.
- 5) Non-noxious administration

Smoke is beyond question the most optimized vehicle of nicotine and the cigarette the most optimized dispenser of smoke.

Let anyone be made unduly apprehensive about this drug-like conceptualization of the cigarette, let me hasten to point out that there are many other vehicles of sought-after agents which dispense in dose units: wine is the vehicle and dispenser of alcohol, tea and coffee are the vehicles and dispensers of caffeine, matches dispense dose units of heat, and money is the storage container, vehicle and dose-dispenser of many things.

So much for extolling the virtues of the rod. Let us go back now and pick up our discussion of the motivational aspects of smoking. If we accept the premise that nicotine is what the smoker seeks, we've still not answered the question "Why do people smoke?" We've merely reformulated it to read "Why does the smoker take

nicotine into his system?"

Systematic research on the question dates back some fifty years to the time when American Tobacco Co. funded the work of a psychologist later to become the most prominent American psychologist of his time. His name was Clark L. Hull. His question then was "Wherein lies the charm of tobacco for those accustomed to its use?"

In order to review the data that has been collected over these intervening fifty years, I have organized it under three headings:

- 1) Differences between smokers and nonsmokers.
- 2) Human physiological responses to inhaled smoke.
- 3) Situational variables related to smoking behavior.

First, then, let us quickly review what is known about the differences between smokers and nonsmokers.

TABLE 1
INDIVIDUAL TRAITS AND GROUP CHARACTERISTICS BY
WHICH A GROUP OF SMOKERS CAN BE DISTINGUISHED
FROM A GROUP OF NONSMOKERS

PERSONALITY TRAITS

- More independent (Pflaum, 1965)
- Greater anti-social tendencies (Smith, 1970)
- More active, energetic (Schubert, 1959; Straits, 1965)
- Higher mean extroversion rating (Smith, 1970)
- "Happy-go-lucky" (Smith, 1969)
- Higher mean measure of "orality" (Smith, 1970)

Poorer mental health (Smith, 1970)

Less rigid, less orderly, more impulsive (Smith, 1970)

Greater reliance on "external" than "internal" controls (Smith,

More chance-oriented (Straits, 1963)

More emotional (Smith, 1967)

Less agreeable (Smith, 1969)

"Type A" personality (More time-conscious, competitive, etc.)
(Rosenman, 1966)

Less "strength of character" (Smith, 1969)

Higher anxiety level (Walker, 1969; Srole, 1968; Thomas, 1968)

LIFE STYLE CHARACTERISTICS

More business-oriented in occupation (Seltzer, 1964)

Poorer academic performance (Veldman and Bown, 1969; Pumroy,
1967; Salber, 1962)

More users of alcohol (Higgins, Kjelsberg, & Metzner, 1967;
Lilienfeld, 1969)

More users of coffee and tea (Lilienfeld, 1959)

Religious service attendance less frequent (Cattell, 1967;
Straits and Schrest, 1963)

Proportionately higher frequency of marriages and job changes
(Lilienfeld, 1959)

Higher incidence of prior hospitalizations (Lilienfeld, 1959)

Higher incidence of smoking among parents (Salber and Abelin,
1967)

More active participation in sports (Lilienfeld, 1959)

More auto accidents (Ianni and Boek, 1958)

MORPHOLOGICAL TRAITS

Greater body weight (Seltzer, 1963)

Greater height (Seltzer, 1963; Baer, 1966)

Thinner (Higgins and Kjelsberg, 1967)

Higher height/(cube root of weight) ratio (Damon, 1961)

Thinner skin folds (triceps and subscapular) (Higgins and Kjelsberg, 1967)

DEMOGRAPHIC CHARACTERISTICS

More men (Public Health Service Publication No. 1000, 1970)

Proportionately more 25-45 year-olds (Public Health Service Publication No. 1000, 1970)

Lower mean socio-economic class (Salber and MacMahon, 1961)

Proportionately fewer college men (Higgins, Kjelsberg, & Metzner, 1967; Lillianfeld, 1959)

More urban residents (Higgins, Kjelsberg, & Metzner, 1967)

Many of these characteristics have little meaning without considerably greater explanation than is appropriate for this presentation. Suffice it to say that the list does summarize our state of knowledge on the smoker-nonsmoker differences. As for the relevance of this knowledge to the question of motivation in smoking, I would say that it is a rich source of hypotheses and hunches, but unfortunately, that is about as far as it can take us. And I regret to say that the major effort of psychologists has been to search for these differences. Hull warned us fifty years ago that the difference approach was a primrose path, but only recently have psychologists begun to appreciate Hull's warning.

The pharmacologists and physiologists have done much better, which leads us to the second body of fact; the human physiological response to smoke. The list in Table 2 again is a summary of our knowledge. To be sure there are other responses, some of which have been noted in the literature, some likely yet to be discovered, but those listed have been reported by at least two non-related laboratories.

TABLE 2
TRANSIENT PHYSIOLOGICAL
RESPONSES TO SMOKE INHALATION

1. Elevated heart rate
2. Elevated coronary flow
3. Elevated blood sugar level
4. Lowered cutaneous temperature in the extremities
5. Increased blood flow in skeletal musculature
6. A reactive release of adrenalin
7. Alterations in electrical potential patterns of the brain
involving alpha wave suppression
8. Inhibition of patellar reflex

Where these responses have been plotted over time, they have been observed to have their onset within several minutes of smoke inhalation, and they are short-lived, having a decay function with a half-life of about thirty minutes. Onset and decay roughly parallel the coincident plotting of nicotine in the bloodstream. (Isaacs & Rand, 1972)

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These facts are considerably more relevant to the motivation question than are the facts about smoker-nonsmoker differences. In psychology, when we talk about motivation we refer to a force which impels one to act, and the action is goal-oriented. Hunger, for example, is a motive which impels one to the action of ingesting food. The goal is a state of satiety. Reaching the goal is the reward, and the behavior which is instrumental in reaching the goal is reinforced.

With this in mind, we can now ask several questions "Are any of the listed physiological reactions sought after by the smoker?", "Are these physiological reactions symptomatic of a body state which is the goal of smoking behavior?"

One feature of the list which has impressed many investigators is its close resemblance to the physiological response pattern accompanying emotional arousal, such as fear, anger, even joy. Is this perhaps the goal of the smoker, to achieve a body state which mimics emotional arousal?

In the context of this question, let us now turn to the third body of fact, the situational variables related to smoking behavior. So as not to bore you with references and the recitation of all the evidence, permit me to present this body of fact in the form of a summary statement: The rate and incidence of smoking varies as a function of external conditions which influence the emotional state of the smoker. The evidence at hand permits us to go one step further; the rate and incidence of smoking is highest at the extremes of the arousal continuum.

If one were to plot smoking rate against some measure of the smoker's level of bodily arousal, one would observe a nice J-shaped distribution. This observation brings us full circle, for you will recall that at the outset of this presentation I quoted the smoker as explaining his smoking in paradoxical terms: It calms me, it stimulates me.

You may also recall that I stated that the challenge to any explanatory theory of smoking is to resolve this paradoxical duality of effect. At the St. Martin conference, Professor Stanley Schachter a psychologist at Columbia University, labeled this as the Nesbitt paradox; Nesbitt being a student of Schachter's who called the paradox to his attention.

Let me state this paradox as clearly and succinctly as I can: The known physiological effects of smoking are those that we consider as indicating body activation or arousal. This fits in nicely with the smoker's statement "It stimulates me". But it is highly discordant with the polar explanation which the smoker provides perhaps even more often - "It calms me". How can an agent which is physiologically arousing be calming? And why should an already aroused, excited person seek further physiological arousal?

Summarizing the known facts pertinent to the question of motivation:

- 1) Smoking is relateable to personality variables.
- 2) Smoke inhalation induces documented physiological responses similar to those induced by emotional arousal.

- 3) Smoking rate varies as a parabolic function of body activation level.

I will end this presentation by summarizing the two major theoretical explanations proposed at the St. Martin conference. We shall see how each attempts to cope with the Nesbitt paradox.

The first is that of Hans Eysenck. To appreciate his explanation of smoking, you must sit still for me to give you a skeletal outline of his theory of personality. Eysenck contends that there are two major dimensions of personality. He uses the poles of the dimensions to label them: extroversion-introversion and neuroticism-stability. He states that the evidence shows no relationship between smoking and the neuroticism-stability dimension. There is, however, abundant evidence of a relationship between smoking and the extroversion-introversion dimension. His explanation for smoking proceeds as follows: Under identical external conditions of low-sensory input, extroverts will have a low level of cortical arousal and introverts a high level of cortical arousal. For every individual there is an optimum level of arousal. Since arousal varies with the level of sensory input, one can visualize as in Figure 1 the relationship of sensory input and hedonic tone, or sense of well-being. It can be seen that, in these terms, too much stimulation is to be avoided, and also too little. Introverts and extroverts require different levels of input for optimum arousal; the extrovert needs more, the introvert less. Extroverts will become stimulus seekers, introverts stimulus avoiders. Drugs are used to alter the level of sensory input. Nicotine is also

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used to alter the level of sensory input. Now we shall see how he resolves the paradox: He acknowledges that nicotine has an arousal, activating effect, and reasons that extroverts therefore should smoke more than introverts. And happily this is true. But what now does he do with his smoking introverts? Surprisingly, he does not attempt to resolve the Nesbitt paradox. He invokes it, pointing out that nicotine can have both arousing and sedating effects. He cites the well-known biphasic action of nicotine as documented by neuropharmacological research. At low concentrations, nicotine activates neural function, at high concentrations, it depresses neural function.

Two serious flaws in Eysenck's reasoning must be pointed out:

- 1) The neuropharmacological evidence for the biphasic action of nicotine is based upon observations of neural tissue response to the local application of nicotine in animal studies. Stimulation occurred at low concentrations of nicotine, depression at high concentration levels. It is absolutely impossible for the concentration level required to induce neural depression to be attained by means of smoke inhalation.
- 2) To postulate both activating and sedating effects is to defy the documented universality of the activating physiological effect of smoke inhalation.

Eysenck, then, has not dealt effectively with the Nesbitt paradox. And I would remark in passing that the theory of Sylvan Tomkins, widely acclaimed in some circles, suffers from the

same criticism. Tomkins has proposed that there are different types of smokers each type seeking different effects from smoking. Tomkins, too, has chosen to overlook the universality of smoke-induced physiological arousal, agreeing with Eysenck that smoking can be either arousing or sedating, depending upon the person and the situation.

The second theoretical explanation from the St. Martin conference is that proposed by Professor Schachter, whom I have already mentioned for coining the phrase "the Nesbitt paradox". Schachter offers an ingenious resolution of the paradox, and an explanation of smoking which you will most certainly find novel and possibly noncredible. Again you must first be briefed on Schachter's theory covering all kinds of affective or emotional experience.

The bodily arousal accompanying emotion is the same for all emotions: fear, anger, joy, etc. The person interprets the bodily emotional state in terms of the circumstances under which the emotion is experienced. Sometimes there are faulty interpretations. These can be dramatically demonstrated in a laboratory setting. An example: A male college student is given adrenaline without his knowledge and under pretext that makes him unsuspecting. All this takes place in the presence of a very attractive female lab assistant. At about the time that the adrenaline begins to take effect the young woman crosses her legs provocatively and lets her hand linger a bit too long on his arm. The subject invariably interprets the adrenaline-induced arousal as an erotic arousal and behaves accordingly. The lab assistant threatened to quit if the experiment were to continue.

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Now how does Schachter apply this theory to resolving the Nesbitt paradox? There is no paradox, of course, in the smoker seeking arousal when at the low end of the arousal continuum, but why seek arousal through smoking when excited, as is so often the case?

I quote him: "As we all know, disturbing and frightening events are presumed to throw the autonomic nervous system into action, epinephrine is released, heart rate goes up, blood pressure goes up, blood sugar increases, and so on. Now notice that many of these physiological changes are precisely those changes that we're told are produced by smoking a cigarette. What happens, then, to the smoking smoker in a frightening situation? He feels the way he usually does when he's frightened but he also feels the way he usually does when he's smoking a cigarette. Does he label his feelings as fright or as smoking a cigarette? I would suggest, of course, that to the extent that he attributes these physiological changes to smoking, he will not be frightened. And this, I propose, is a possible explanation for the strikingly calming effect that smoking a cigarette had on the chronic smokers in Nesbitt's experiments."

There is a variant on the Schachter hypothesis that should properly be ascribed to Frank Ryan, one of my psychologist colleagues at the Philip Morris Research Center.

Ryan suggests that arousal by smoking is perhaps a means of muting or damping an arousal response to exciting or disturbing circumstances. There are limits within which a person will operate

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on the arousal continuum. If pushed up toward the upper limit by smoke inhalation, there is little room left for further arousal by external events. Thus the smoker can prep himself against the disturbing effect of anxiety or fear, or anger or whatever.

This is the end of my presentation. If you have been intrigued by any of these ideas, I recommend the recently published volume entitled "Smoking Behavior: Motives and Incentives", a compendium of papers presented at the St. Martin Conference, published by V. H. Winston & Sons of Washington, D.C.

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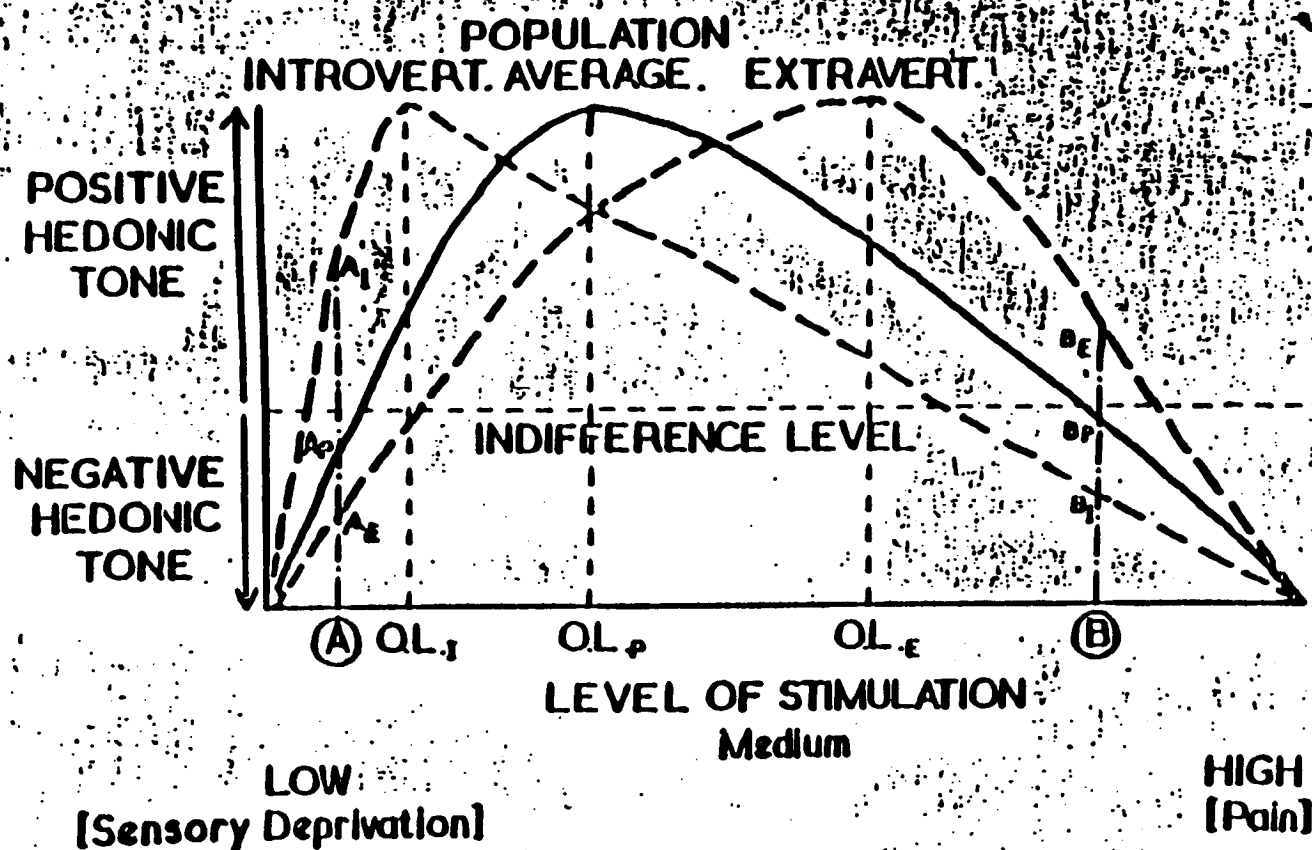


Figure 4. Relation between level of sensory input and hedonic tone as a function of personality. Reprinted from H. J. Eysenck, 1963.

CONFIDENTIAL

Forillard

MEMORANDUM

June 14, 1974

CONFIDENTIAL

TO: Mr. C. H. Judge

FROM: A. W. Spears

PLAINTIFF'S
EXHIBIT

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Before attempting to discuss CTR, a brief review of the organizations contributing to research into tobacco and health seems to be appropriate. Perhaps the simplest way to review the subject is to list the organizations and/or category of organization and general areas of research which they are pursuing.

1. Harvard Project - effect of smoke on host genetics and lung function; especially, lung defense mechanisms as mediators of bronchitis and emphysema.

2. Washington University - early detection of cancer by immunological methods and function of the immune system in tumor regression and/or prevention.

3. UCLA - macrophage morphology and function differences between smokers and nonsmokers. Cancer immunology, early diagnosis through cell culture methods and cancer chemotherapy.

4. Chemical Companies - development of tobacco substitutes using chemical and bioassay methods to indicate differences from tobacco. Some human experiments relating to bronchitis are being conducted.

5. Filter Companies - development of filters which alter composition of tobacco smoke. Total particulate reduction, vapor phase reduction and reduction of carbon oxides and oxides of nitrogen.

7. Tobacco Research Council - Harrogate Laboratories have been sold, but research on inhalation and cellular effects of smoke continue under contract. Also, it would appear that some results of Harrogate studies are being pursued directly by individual companies in house. The aim would be highly product orientated.

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ALLIANCE LEGAL SUPPLY CO.

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EXHIBIT NO. 10

R. APPLEBAUM

June 24, 1974

CONFIDENTIAL

8. University of Kentucky - broad spectrum of chemical and bioassay development programs. Epidemiology into smoke dose obtained by smokers who enter hospital and those that do not. Primary emphasis seems to be tumorigenesis and chronic pulmonary disease. Program does include agronomical aspects.

9. USDA - program is concentrated on new varieties, curing process, etc. as means of manipulating tobacco. Program utilizes NCI bioassay systems and chemical analysis of smoke.

10. State Agriculture Research - program relates to pesticide residues and breeding for low tar and nicotine.

11. Tobacco Sheet Manufacturers - attempting to make tobacco sheets with improved bioassay results. Utilizing NCI and German Institute for bioassay.

12. NCI and NHLI - programs relate to development of bioassay system for tobacco smoke. Evaluation of different products by these bioassay procedures is prime part of program. Emphasis is on tumorigenicity, but programs for cardiovascular disease and chronic pulmonary disease are being initiated.

13. Ad Hoc Committee - most research is epidemiological in nature. Program is primarily aimed at seeking alternate hypothesis of disease causation.

14. CTR - epidemiology, bioassay development, genetics, primarily aimed at tumorigenesis and chronic pulmonary disease, but some activity in cardiovascular disease and smoking motivation.

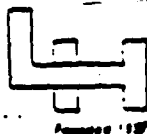
Exclusive of the CTR program, the total annual research funding of the listed organizations is on the order of 25 million dollars directly related to smoking and health. Additionally, the federal government is spending on the order of 700 million in the general disease areas of cancer, chronic pulmonary disease and cardiovascular disease. Clearly, CTR is conducting research in a highly competitive area, and the programs must be well conceived and targeted to avoid unwanted duplication and produce significant results.

Sometime ago (1970), the CTR program was evaluated by the Research Directors. At that time, it was felt that the desired aims of the CTR program could be stated as:

1. To define the effects of cigarette smoke on the human system.
2. To conceptualize and explore other hypotheses relative to the smoking and health question by epidemiological and other appropriate methods.

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LENOX HILL HOSPITAL

100 EAST 77TH STREET / NEW YORK N.Y. 10021

RECEIVED

August 7, 1975

AUG 3 - 1975

Dr. William Gardner
Council for Tobacco Research
110 East 59th Street
New York, New York 10022

CONFIDENTIAL

Dear Bill:

Herewith is a more considered report of my opinions concerning the UCLA research effort supported by the tobacco companies.

1. In competition, would this package likely be given top priority for NIH, CTR or American Cancer Society funding? Ans- No.
2. What parts likely would be funded elsewhere? Ans- Bone marrow transplantation in man. Bone marrow culture systems. Perhaps leukocyte assay systems.
3. What is the strongest part of the program? Ans- Bone marrow transplant (Gale).
4. The weakest? Tumor immunology (Bloom). Vit B 12 antagonists (Tockay). Alveolar proteinosis (Terrico).
5. Is a five-year commitment too long? Ans- Yes.
6. Is the research respectable? Ans- Yes.
7. Is there relevance to smoking and health? Ans- Very little, and it is dragged into the program.
8. Is the money well spent in the interests of humanity? Ans- doubtful.

What is represented in this group is a loose confederation of academic researchers and practitioners of hematology and cancer therapy. Emphasis is on academic accomplishments. The research, except for that of Haskell, Gale and Golde, appears Uninspired. The goals are laudable, but the spark for exceptional accomplishment is not there. The group, with the exceptions noted, will go on churning out papers, speaking at meetings, and using up money to the end of time without much effect on the science or art of medicine. It is in effect a lamasery that is being supported.

I do not know how to express adequately a kind of regret that through multiple layers of misunderstanding between the donors and recipients of these funds an attempt to do good has gone astray. Perhaps one might say that this program overall might do some good and probably would not do any particular harm.

If you want a detailed analysis by individual subprojects, please let me know.

Best wishes,

Sheldon G. Sommers
Sheldon G. Sommers, M.D.
Director of Laboratory

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2. Develop hardware and facilities for long term chronic smoke inhalation studies with a tumorigenic end point.

3. Determine tumorigenic activity of smoke fractions.

4. Determine if reported environmental carcinogens interact with tobacco smoke.

5. Develop new short term bioassay systems for carcinogenesis.

A review of the individual projects under lung and pulmonary studies indicates that the objectives are diffuse compared to cancer.

1. Determine effect of smoke by chronic inhalation in mice.

2. Explore various facets of lung metabolism, defense mechanisms, etc.

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Forillard

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CONFIDENTIAL

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FROM: A. W. Spears

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R. APPLEBAUM

June 14, 1974

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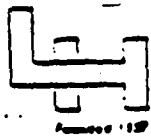
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LENOX HILL HOSPITAL

100 EAST 77TH STREET / NEW YORK N.Y. 10021

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AUG 3 - 1973

August 7, 1973

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2. Develop hardware and facilities for long term chronic smoke inhalation studies with a tumorigenic end point.

3. Determine tumorigenic activity of smoke fractions.

4. Determine if reported environmental carcinogens interact with tobacco smoke.

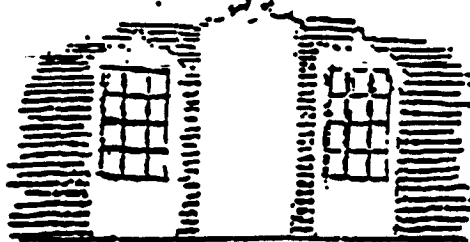
5. Develop new short term bioassay systems for carcinogenesis.

A review of the individual projects under lung and pulmonary studies indicates that the objectives are diffuse compared to cancer.

1. Determine effect of smoke by chronic inhalation in mice.

2. Explore various facets of lung metabolism, defense mechanisms, etc.

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Pedco Brian Associates, Inc., 107 East 38th Street, New York, N.Y. 10016 - Lexington 2-261

August 13th, 1970

Professor Charles Seide
Cooper Union
Cooper Square
New York, New York

Dear Professor Seide:

We're adults. You've got a group of talented kids. Hence this letter...

We have been asked by our client to come up with a package design....a design that is attractive to kids....(young adults). We were wondering if this project might serve as a challenging assignment for your package design class(es).

The assignment is as follows:

To design a cigarette package and cigarette carton that has selling appeal to the "youth market". The new product name is "Kicks". (a new cigarette)

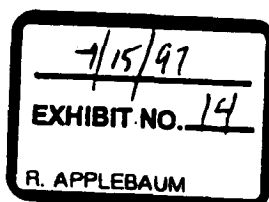
Guidelines that must be followed include:

A. The actual package contains ten cigarettes.... not the usual twenty.

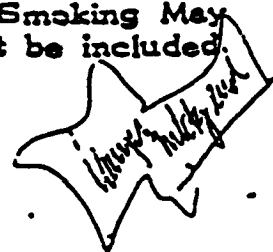
B. The words: "delux length" must appear on the package.

C. The words: "a product of Lorillard Greensboro, N.C., U.S.A." must also appear.

D. The words: "Caution: Cigarette Smoking May Be Hazardous To Your Health" must be included on the package.

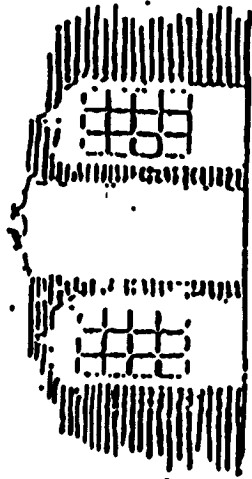


A SALES PROMOTION AGENCY



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Reim. Enclosure, Fra. 107 Post 38th Street New York, N.Y. 10016. Remington 2-261

Cont. Professor Selde

E. The "seal closure" on the package top must say "a product of Lorillard, 10 cigarettes Class (A)."

Note: While this cigarette is geared to the youth market, no attempt (obvious) can be made to encourage persons under twenty-one to smoke. The package design should be geared to attract the youthful eye....not the ever-watchful eye of the Federal Government.

If one of your students presents a package-carton design(s) that is accepted (design chosen for new package-carton) either that person will be awarded an agreed upon sum of money, or your school will be given an agreed sum of money for scholarships. These methods of payment, along with any others that you might suggest, can be discussed at a later date.

I don't know if you can entertain such an idea for a class project, but I would appreciate hearing from you regarding same.

Sincerely,

Philip Gaberman
Philip Gaberman
Creative Director

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A SALES PROMOTION AGENCY

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RESEARCH PLANTING RESEARCH

OR

SOME THOUGHTS ABOUT NEW BRANDS OF CIGARETTES
FOR THE YOUTH MARKET

EXHIBIT NO. 14
4/14/97
H. APPLEBAUM

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SOME THOUGHTS ABOUT NEW BRANDS OF CIGARETTES
FOR THE YOUTH MARKET

At the outset it should be said that we are presently, and I believe unfairly, constrained from directly promoting cigarettes to the youth market; that is, to those in the approximately twenty-one year old and under group. Statistics show, however, that large, perhaps even increasing, numbers in that group are becoming smokers each year, despite bans on promotion of cigarettes to them. If this be so, there is certainly nothing immoral or unethical about our Company attempting to attract those smokers to our products. We should not in any way influence non-smokers to start smoking; rather we should simply recognize that many or most of the "21 and under" group will inevitably become smokers, and offer them an opportunity to use our brands.

Realistically, if our Company is to survive and prosper, over the long term we must get our share of the youth market. In my opinion this will require new brands tailored to the youth market; I believe it unrealistic to expect that existing brands identified with an over-thirty "establishment" market can ever become the "in" products with the youth group. Thus we need new brands designed to be particularly attractive to the young smoker, while ideally at the same time being appealing to all smokers.

Several things will go to make up any such new "youth" brands, the most important of which may be the image and quality - which are, of course, interrelated. The questions then are: What image? and What quality? Perhaps these questions may best be approached by consideration of factors influencing pre-smokers to try smoking, learn to smoke and become confirmed smokers.

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Table I attempts to define some of the more important effects expected or derived from cigarette smoking by pre-smokers, "learning" smokers and confirmed smokers. If this incomplete, subjective, simplistic analysis is even approximately correct, there are sharp, perhaps exploitable, differences between pre-smokers, "learners" and confirmed smokers in terms of what they expect or derive from smoking. Let us examine these differences.

For the pre-smoker and "learner" the physical effects of smoking are largely unknown, unneeded, or actually quite unpleasant or awkward. The expected or derived psychological effects are largely responsible for influencing the pre-smoker to try smoking, and provide sufficient motivation during the "learning" period to keep the "learner" going, despite the physical unpleasantness and awkwardness of the period.

In contrast, once the "learning" period is over, the physical effects become of overriding importance and desirability to the confirmed smoker, and the psychological effects, except the tension-relieving effect, largely wane in importance or disappear.

The common thread binding the three groups together appears to be the fact that smoking of cigarettes offers and provides a desired mechanism for coping with the stresses of living, which may range from boredom to high tension and from fatigue to high arousal and hyperactivity. Once this mechanism has been experienced and used, physical and psychological habit patterns are firmly established and become self-perpetuating.

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TABLE I
EFFECTS EXPECTED OR DERIVED FROM CIGARETTE SMOKING

	<u>Pre-Smoker¹</u>	<u>Learner¹</u>	<u>SMOKE¹</u>
<u>I. PHYSICAL EFFECTS</u>			
<u>A. Nicotine Response</u>	0	+	+
<u>B. Sensory Effects</u>			++
<u>1. Irritancy-Harshness</u>	0	-	+
<u>2. Flavor</u>	+	-	+
<u>3. Other Mouth Feel</u> - Dryness, Astringency, etc.	0	-	+
<u>4. Visual</u> - Pack, cigarette and smoke attributes	0	+	+
<u>C. Manipulative Effects</u> - Handling, lighting, puffing, holding, ashing, extinguishing	-	-	+
<u>II. PSYCHOLOGICAL EFFECTS</u>			
<u>A. Group Identification</u> - Participating, sharing, conforming, etc.	++	++	+
<u>B. Stress and Boredom Relief</u> - Buys time, valid interruption, bridges awkward times and situations, something to do, etc.	+	++	+
<u>C. Self-Image Enhancement</u> - Identification with valued persons, daring, sophisticated, free to choose, adult, etc.	++	++	-
<u>D. Experimentation</u> - Try something new, experiment, etc.	++	++	0
<p><u>+</u> = positive</p> <p>0 = none</p> <p>- = negative</p>			

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If the above analysis is approximately correct, then the basic theme for promoting any cigarette to any group should aim, directly or indirectly, at the desirability of using a given brand as a mechanism for coping with stress. Brands tailored for the beginning smoker should emphasize the desirable psychological effects of smoking, also suggesting the desirable physical effects to be expected later. Happily, then, it should be possible to aim a cigarette promotion at the beginning-smoker, at the same time making it attractive to the confirmed smoker. The information and outline in Table I then may be used as a basis for arriving at some specifications for new "youth" brands and for determining how they should be promoted.

I. PHYSICAL EFFECTS

Having identified these as highly desirable to the confirmed smoker but largely unknown, unpleasant, awkward and/or undesirable to the pre-smoker or "learner", the effort here should be to affect a compromise to minimize the undesirable effects while retaining those which later become desirable.

- A. Nicotine Effects - Nicotine should be delivered at about 1.0-1.3 mg./cigarette the minimum for confirmed smokers. The rate of absorption of nicotine should be kept low by holding pH down, probably below 6.

B. Sensory Effects

1. Irritancy-Harshness - The beginning smoker and inhaler has a low tolerance for smoke irritation, hence the smoke should be as bland as possible.
2. Flavor - The flavor of tobacco smoke is initially foreign, and not pleasant. One cultivates a taste for smoke such as one learns to like olives or dry wines. Perhaps, as in the case of taste of water, there is no really "good" flavor, only degrees of "bad" flavor. Thus for the beginning smoker the cigarette smoke should have a

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moderate level of blended tobacco flavor, but should be as free as possible from strong, unpleasant flavors such as starchy flavor, etc. A "tar" delivery of 12-14 mg/cigarette should provide the desired flavor level.

3. Other Mouth Feel - The smoke should be "bland" with respect to astringency, hotness, dryness and the like. Again, the theory is that any mouth effect is new and different, hence should be as bland and free of obvious negatives as possible.

4. Visual - The package and cigarette should be pleasing to the eye, as will be discussed further below. The amount and density of exhaled smoke should be such as to be clearly visible and not thin or scanty. A tar level of 10-14 mg/cigarette should meet this requirement.

C. Manipulative Effects - Carrying, opening and using the package should be convenient. The cigarette should be as long as possible, probably 100 mm, to facilitate lighting. The rod should be reasonably firm, and a moderately soft, round filter tip should be used. The draft resistance prior to and during smoking should be as low as practical and should not exceed VANTAGE specifications. The product should require, thus, minimum effort and care to handle and use.

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II. PSYCHOLOGICAL EFFECTS

These are the expected or derived gratifications which influence a pre-smoker to try smoking and which sustain the beginning smoker during the largely physically awkward and unpleasant "learning to smoke" phase. These effects also largely determine which brand the pre-smoker will experiment and learn with.

A. Group Identification - Pre-smokers learn to smoke to identify with and participate in shared experiences of a group of associates. If the majority of one's closest associates smoke cigarettes, then there is strong psychological pressure, particularly on the young person, to identify with the group, follow the crowd, and avoid being out of phase with the group's value system even though, paradoxically the group value system may esteem individuality. This provides a large incentive to begin smoking. If this be true, then the same effect strongly influences the brand chosen, it likely being the popular, "in" brand used by one's close associates.

Thus a new brand aimed at the young smoker must somehow become the "in" brand and its promotion should emphasize togetherness, belonging and group acceptance, while at the same time emphasizing individuality and "doing one's own thing."

B. Stress and Boredom Relief - The teens and early twenties are periods of intense psychological stress, restlessness and boredom. Many socially awkward situations are encountered. The minute or two required to stop and light a cigarette, ask for a light, find an ash tray, and the like provide something to do during periods of awkwardness or boredom, and afford a little "time-out period" when confronting a stressful situation. Smoking also gives one something to do with the hands, eyes, etc. and something to talk about in a situation where otherwise one might simply have nothing to do or say.

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This desirable attribute of smoking should be strongly emphasized in promoting a new youth brand.

C. Self-Image Enhancement - The fragile, developing self-image of the young person needs all of the support and enhancement it can get. Smoking may appear to enhance that self-image in a variety of ways. If one values, for example, an adventurous, sophisticated, adult image, smoking may enhance ones self-image. If one values certain characteristics in specific individuals or types and those persons or types smoke, then if one also smokes he is psychologically a little more like the valued image. This self-image enhancement effect has traditionally been a strong promotional theme for cigarette brands and should continue to be emphasized.

D. Experimentation - There is a strong drive in most people, particularly young, to try new things and experiences. This drive no doubt leads many pre-smokers to experiment with smoking, simply because it is there and they want to know more about it. A new brand offering something novel and different is likely to attract experimenters, young and old, and if it offers an advantage it is likely to retain these users.

There is another psychological factor which did not readily fall into Table I, but which may be quite important. That category might be called "Anti-Establishment Attitudes". It does not enter into the decision to start smoking but may strongly influence the brand chosen. Today more than ever, young people tend to reject whatever is accepted by the "over-thirty" establishment, which includes their parents. If "Brand JO" is the accepted "in" brand with the establishment, it is likely that many young smokers will

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almost automatically reject that brand and start with something else. They will more likely start with "Brand 20+" which is both the "in" thing with their closest age group and the "out" thing with the "over-thirty" group. Probably in today's market, WINSTON is the "Brand 30+" and Marlboro is the "Brand 20+". Happily, the Marlboro will eventually age out of its "in" position with youth, as WINSTON appears to have already done. Now is the time to launch the next brand to become the "in" cigarette with the next generation as Marlboro ages from "in" to, hopefully "out and over-thirty" status, hence becomes something for youth to avoid.

A final psychological factor which also did not fall readily into Table I involves smoking-health attitudes. The smoking-health controversy does not appear important to the group because, psychologically, at eighteen, one is immortal. Further, if the desire to be daring is part of the motivation to start smoking, the alleged risk of smoking may actually make smoking attractive. Finally, if the "older" establishment is preaching against smoking, the anti-establishment sentiment discussed above would cause the young to want to be defiant and smoke. Thus, a new brand aimed at the young group should not in any way be promoted as a "health" brand, and perhaps should carry some implied risk. In this sense the warning label on the package may be a plus.

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at the youth market should have. At this point, it will be useful to summarize what has been said; in admittedly general terms:

Product Quality Factors

1. Moderate level of nicotine (1.0-1.3 mg/cigarette) delivered at pH (5.8-6.0) to insure slow absorption.
2. Moderate level of blended tobacco flavor ("tar" of 12-14) free of undesirable (e.g. starchy) flavors.
3. Bland, soft, moist mouth-feel, with minimal irritancy, harshness, astringency, possibly very lightly mentholated.
4. In "standard" range of diameter and firmness, with resilient filter or mouthpiece, probably 100 mm in length.
5. Different package type or packaging material, perhaps containing fewer cigarettes, therefore less bulky.
6. Some visible novelty or difference in product or package to set apart from conventional cigarettes, ideally in direction of greater manipulative convenience for beginning smoker.

Product Image Factors

1. Should emphasize participation, togetherness, and membership in a group, one of the group's primary values being individuality.
2. Should be strongly perceived as a mechanism for relieving stress, tension, awkwardness, boredom, and the like.
3. Should be associated with doing one's own thing to be adventurous, different, adult, or whatever else is individually valued.
4. Should be perceived as some sort of new experience, something arousing some curiosity, and some challenge.
5. Should be different from established brands used by the over-thirty and perhaps even over-twenty-five groups. Must become the proprietary "in" thing of the "young" group.
6. Should not be perceived as a "health" brand.

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The enumerated Product Quality Factors should be easy to achieve, except those requiring some ill-defined novelty. The Product Image Factors, of course, describe a promotional approach, and it is most likely that the name and appearance of the product will here become crucial in establishing the desired image. The name may be the most important factor, determining the appearance of the package and summarizing the image to be promoted.

Ideally, the name chosen should have a double meaning; that is, one desirable connotation in "straight" language and another in the jargon of youth. A current example may be Kool, which reads on "cool" cat in youth jargon, and also literally connotes a refreshing physical sensation. Another way of approaching the name or image would be to choose one which evokes different but desirable responses from different age groups. Thus the Marlboro western theme suggests independence, clear air, open spaces and freedom to the youth group, while at the same time suggesting the "good old days", hard work, white hats over black hats, and the like to the older generation. In passing, it is interesting to note that Marlboro is a distinguished, dignified British name, and there is a certain inconsistency in equating this image with the West.

A careful study of the current youth jargon, together with a review of currently used high school American history books and like sources for valued things might be a good start at finding a good brand name and image theme. This is obviously a task for marketing people, not research people.


Assuming that at some point marketing people will establish a name and image for a new youth brand, and assuming that the thoughts on product quality factors expressed above are approximately correct, then Research and TPD should be able to provide the product needed. Most of the product specifications defined are achievable with present technology. Those which require new technology would appear to be (1) control of irritancy and related mouth-feel factors to produce a bland

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smoke, and (2) creation of some useful, demonstrable novelty in filter, mouthpiece, package or other aspect of the product system.

Our Company needs to take advantage of the opportunity to market new youth brands of cigarettes. The thoughts expressed here may provide a preliminary agenda for discussions between Research, TPD, Marketing and Management, aimed at more precisely defining what we could ultimately make and promote. It is hoped that such discussions will soon ensue. Meanwhile, it becomes appropriate for Research to seek ways to control smoke irritancy and to seek to create novel, useful cigarette systems.


 Claude E. Teague, Jr.
 February 2, 1973

:jhb

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RJR

Inter-office Memorandum

Subject: New Project Area Proposal
Title: Smoking Behavior Studies -- A Pathway
to New Product Concepts

Date: September 21, 1971

To: Dr. A. H. Laurene

From: D. H. Piel

Project Undertaking: To study all aspects of human smoking behavior, providing experimental data where necessary, and develop a comprehensive view of how and why people smoke, why they don't smoke, and identify specific needs that are fulfilled by smoking.

Objective: The ultimate objective is to develop new product concepts that fulfill needs for the non-smoker.

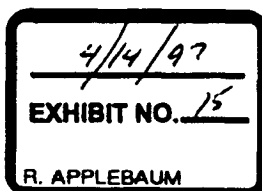
Summary: We normally seek to learn as much as we can about the chemistry and organoleptic properties of tobacco smoke, but little consideration has been given to the nature of our consumer from a research standpoint. Much research has been done on the psychological and physiological aspects of smoking outside of the industry but this information is not effectively used. Very little has been done on the social and psycho-social aspects of smoking. And practically nothing has been done on the physical and anatomical aspects of how a person smokes.

It is clear that people smoke for many more reasons than just pleasure. Smoking is a unique human behavioral function and there are many preconceived notions and biased explanations for its use. We should examine all aspects of this behavior to get a complete and accurate picture from which long range product concepts can be developed.

It is proposed to form a multidisciplinary team of scientists to examine the smoking process and smoker behavior, each from his own special point of view, drawing mainly on existing data. This team might initially consist of one full time RJR scientist familiar with tobacco and smoke, and a Marketing Research person together with part-time consultants. However, to be truly effective this would have to develop into a continuing effort perhaps requiring the need for recruiting specialized scientists or retaining permanent consultants.

The only laboratory research to be done at RJR would be studies of mouth-smoke interactions and the physical mechanism of the smoking process.

As a better picture of how and why people smoke emerges, new ideas of need satisfiers for the non-smoker should also emerge. In this way entirely new product concepts should arise having a sound scientific motivation for their development.



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Status:

Impetus for this proposal was generated from previous puff profile and retention studies but with the exception of oral pH measurements and discussion of possible physiological experiments to be done at IBT, no new research has been initiated.

Memorandum:Background

Our primary product is tobacco smoke and much research effort is devoted to its chemistry and taste, yet behavioral scientists tell us that people do not smoke just for pleasure (1). Americans, they suggest, smoke for many psychological and social reasons, such as to prove that they are virile; to demonstrate their energy, vigor, and potency. In addition they suggest people smoke because cigarettes relieve tension, express sociability, are rewards for effort, are aids to poise, help anticipate stress, etc. Many physicians, physiologists and pharmacologists argue that while the onset of smoking is determined by an interaction of social and psychological factors, its maintenance is due largely to the dependence on the pharmacological effects of nicotine (2). Much medical research is devoted to the study of allegedly hazardous components of smoke and their effect on the body. The social and psycho-social aspects of smoking are just beginning to be investigated in any detail (3).

It is clear that there is a lot more to smoke and smoking than we are generally cognizant of. Some experience has been gained here through the study of puff profile characteristics and lung deposition measurements. However, little effort has been devoted to the physical mechanism of the smoking process itself, especially with regard to interactions in the mouth.

This was not intended to be a rigorous review, but simply to provide an introduction to the proposal.

Proposal

In view of the many factors involved in dealing with cigarette smoking and smoker behavior it seems important if not vital to take all of these factors into consideration in undertaking a viable research effort as part of our opportunity-oriented program.

It is proposed that one RJR scientist be assigned to develop and coordinate a plan to assimilate and evaluate existing knowledge of smoker behavior. This could also include a Marketing Research person. Initially, this might involve retaining specific behavioral science consultants in the areas of psychology, physiology, sociology, etc., in addition to extensive literature review. Eventually it might require the recruiting of new scientists with new disciplines.

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Periodic reviews or group discussions would be held in an attempt to establish the type of information that would be necessary for new concept development. Answers to the following questions would be sought:

1. Why do people smoke?
2. Why don't people smoke?
3. What specific needs are fulfilled by smoking?
4. Can these needs be fulfilled by other means? and if so.
5. Can new consumer product concepts be developed utilizing these means?

This type of information would also be valuable in other aspects of tobacco and smoke research. We cannot thoroughly understand our product if we do not understand how and why it is used. Since smoking is a unique human experience we cannot rely on those who do not have a vested interest to explain the reasons for smoking behavior.

Active research should be undertaken to define the physical mechanism of the smoking process. Looking at the human system, particularly the mouth, as a reaction vessel, how does the smoke enter, what happens to it, how long does it stay, and how does it leave? These somewhat elementary aspects of smoking have not been given enough consideration. This work would relate closely to existing experiments on the effect of smoke on oral pH. In fact, it may be necessary before an adequate experimental design can be developed. This work would also relate to possible experiments at IBT to measure physiological response of various tobacco products.

If we take the view that our single biggest product is some form of oral satisfaction as a basic need satisfier then we should know everything there is to know about it and how these needs might be fulfilled in other ways. This may involve subjects or disciplines that are not considered to be within the realm of tobacco research and may require changes in attitude. It is clear that there is a void in our total approach to smoke and smoking. Fulfilling this void could capitalize on our superior marketing expertise with new consumer products.

D. H. Lehl
D. H. Lehl

DHP/kl

Cc: Dr. Murray Senkus
Dr. C. E. Teague, Jr.

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1. "Cigarettes: Their Role and Function." A study for the Chicago Tribune, Social Research, Inc., Chicago, Ill. (~1955).
2. Russell, M.A.H., Br. Med. Journ. 2 (5751) 330-331 (May 8, 1971).
3. Zagona, S.V., Ed. "Studies and Issues in Smoking Behavior," University of Arizona Press. Tuscon, Arizona, 1967.

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PUBLIC SMOKING

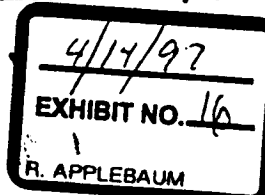
In 1971, Jesse L. Steinfeld, M.D., then U.S. Surgeon General, advocated the prohibition of smoking in confined public places, such as restaurants, theaters, airplanes, trains and buses, because the nonsmoker might be injured by ambient tobacco smoke (i.e., tobacco smoke in the atmosphere).

Steinfeld's statement gave anti-smoking groups an effective theme. The anti-smoking organizations adopted the objective that smoking should be made socially unacceptable. They began a mass invasion of state capitals and city halls to argue that laws must be enacted to protect the nonsmoker from ambient tobacco smoke forced on him by smokers in public places.

CHRONOLOGY

The following is a brief sketch of major events at the state and local level subsequent to Steinfeld's clarion call.

- 1970 Ten bills introduced to restrict smoking in public places; none enacted.
- 1971 Twenty-eight bills introduced in five states; two enacted.
- 1972 Sixteen bills proposed in 12 states; two enacted. HCA adopted guidelines which prohibited smoking in conference rooms and auditoriums in its buildings and required no smoking sections in its cafeterias.
- 1973 Thirty-six bills proposed in 18 states; five enacted. Many municipalities enacted restrictive ordinances. The Arizona restrictive law and its promoter, Mrs. Betty Carnes, received wide publicity. The CAB ordered commercial airliners to separate smokers and non-smokers.
- 1974 Sixty-two bills proposed in 29 states; five enacted. Several municipal ordinances restricting smoking also were enacted. The ICC restricted smokers to the rear 20 percent of seating space on interstate buses.
- 1975 One hundred sixty restrictive smoking bills introduced in 48 states; 17 enacted. The Minnesota Clean Indoor Air Act restricted smoking in a broad range of public and commercial areas. The New York Health Department prohibited smoking in public areas, including supermarkets.



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1976

One hundred sixty-one bills proposed in 39 states; eight enacted, including the Utah Clean Indoor Air Act, another broad no smoking bill. Lawsuits were filed against the Pontiac, Michigan, Stadium Authority and the New Orleans Superdome by anti-smokers seeking to prohibit smoking in the buildings. The court dismissed the Superdome action and the Michigan lawsuit was settled with an agreement that the stadium would request the public not to smoke except in concourses. The ICC prohibited smoking in railroad dining cars and required separate passenger cars for smokers and non-smokers. Donna Shimp sued her employer, New Jersey Bell Telephone Company, and obtained an injunction requiring the company to provide her with a smoke-free working environment. Ms. Shimp was an ex-smoker who claimed she had a rare eye condition which was aggravated by tobacco smoke.

10.

1977

One hundred thirty-six restrictive bills introduced in 44 states, 13 enacted. The General Services Administration (the caretaker for U. S. Government buildings), the State Department and the Department of Defense enacted restrictive smoking guidelines for buildings under their control. The FAA rejected a petition by a Nader group which requested a prohibition against smoking by pilots on the flight deck of airliners. The CAB voted to prohibit pipe and cigar smoking in interstate airlines and announced that it would consider a rule prohibiting cigarette smoking.

11.

1978

As of May 1, 97 restrictive bills were introduced in 25 states, and three were enacted. As a part of HEW's "War on Smoking" program, HEW promulgated new restrictive smoking rules for buildings under its control and announced its intention to urge businesses and state and local governments to adopt restrictive smoking rules. California GASP and Californians for Clean Indoor Air obtained sufficient signatures to place a broad anti-smoking initiative on the ballot for the California general election in November. Twenty-six restrictive measures were proposed in local governments and eight have been enacted. In April the New Jersey Public Health Council added a broad no smoking in public provision to the New Jersey Sanitary Code, which is enforceable as law, effective July 1, 1978. Implementation of the new Code provisions may be delayed at the request of the New Jersey legislature.

12.

Anti-smoking groups have continued to enjoy their greatest successes at the local government level. Most major cities now have restrictive smoking ordinances. There are

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in

more than 225 local governments with restrictive ordinances reported to the Tobacco Institute. The actual number is probably larger.

THE LAWS AND ENFORCEMENT

Thirty-two states and the District of Columbia have enacted legislation restricting smoking in at least one category of public places. Of those 32 states, the majority have enacted prohibitions or restrictions applicable to elevators, public transportation, theaters, museums, libraries, concert halls, health delivery facilities, health care facilities, government buildings and public meeting places. Six of the 32 states have prohibited smoking or require segregation of smokers in retail stores, food stores, and restaurants. Two states (Minnesota and Utah) extend their restrictions to privately owned places, including offices where more than one person works.

14.

The Minnesota Clean Indoor Air Act is one of the two broadest state restrictive laws in the United States and has become the model for anti-smoking legislation. The law prohibits smoking in public places except in designated smoking areas. The Act defines "public place" as:

15.

...any enclosed, indoor area used by the general public or serving as a place of work, including, but not limited to, restaurants, retail stores, offices and other commercial establishments, public conveyances, educational facilities, hospitals, nursing homes, auditoriums, arenas and meeting rooms, but excluding private, enclosed offices occupied exclusively by smokers even though such offices may be visited by nonsmokers.

Smoking areas may be designated by proprietors of public places, provided that:

16.

...where smoking areas are designated, existing physical barriers and ventilation systems shall be used to minimize the toxic affect of the smoke in adjacent nonsmoking areas.

Current trends in state laws and local ordinances actually enacted are the extension of smoking restrictions to cover government-owned buildings, grocery stores, supermarkets and health care and delivery facilities. The major trend in the bills introduced, reflecting the ambition of anti-smoking supporters, is the extension of restrictions into the workplace, including offices.

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Reported enforcement activities appear to be the result of either official priorities set by the local administration or, more frequently, random efforts by local GASP chapters to obtain enforcement of the laws.

18.

In Chicago, smoking on Transit Authority trains and buses is punishable by fines of \$50 to \$300. Offenders are tried in "Smokers' Court," where more than 800 people were convicted in 1975. People who could not post the \$25 bond had to spend the night in jail. Even those who could post bond often had to spend several hours in custody before cutting the red tape and winning release. Smokers have been taken bodily from trains because they protested their arrest. Ninety percent of the arrests have involved minority and low income groups.

19.

However, in most cities which have enforced public smoking laws, actions have resulted from private complaints and citizens' arrests made by private individuals, usually members of GASP. Most reports of enforcement from citizens' arrests come from California cities. The laws of most states do not authorize a citizen's arrest for violation of no smoking laws, but in California smokers can be arrested by fellow citizens.

20.

Yet the primary impact of smoking restriction laws may be the creation of a no-smoking norm in public places. The Commissioner of Dade County, Florida, admitted that that county's anti-smoking ordinance was virtually unenforceable but added:

21.

But it's being morally enforced; it's the people, the people in the elevators, the clerks in the stores and the nonsmokers in the check-out lines, who by their remarks to offenders are enforcing the law. It's being enforced by people who want to obey the law and I'd say it was 85% to 90% effective.

The impact of no-smoking laws on the cigarette market has not been accurately measured. However, to gauge the impact it is helpful to remember that the average smoker in the United States consumes 1.5 packs per day. If it is assumed that smoking prohibitions in public places caused the average smoker to consume one less cigarette per day, total consumption in the U.S. would be reduced by 1/30th.

22.

THE MEDICAL FACTS

In 1971, Jesse L. Steinfeld, M.D., who served as U.S. Surgeon General from 1968 to 1973, said:

23.

Evidence is accumulating that the nonsmoker may have untoward effects from the pollution his smoking neighbor forces upon him.... It is high time to ban smoking from all confined public places such as restaurants, theaters, airplanes, trains, and buses....

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There was no evidence in the speech, and there had been no evidence in previous Public Health Service (PHS) reports to Congress on smoking and health signed by the Surgeon General (commonly called the Surgeon General's Report). In fact, a previously published PHS booklet entitled "Smoking, Health, and You" stated that the smoke from other people's cigarettes "may make your eyes tear or may make you cough, but it cannot harm you...."

24.

The next report to Congress on smoking and health, the 1972 edition, for the first time cited reports indicating that ambient tobacco smoke could be harmful to nonsmokers. The evidence was not convincing and strong contrary evidence was omitted.

25.

Anti-smoking groups have repeated Dr. Steinfeld's claims in forums throughout the United States and have expanded them to include assertions about a variety of potential injuries to nonsmokers from exposure to ambient tobacco smoke.

26.

The anti-smokers' claims that nonsmokers can be injured by ambient tobacco smoke are not supported by scientific evidence. It is instructive to examine a few of these claims in the light of scientific and medical knowledge.

27.

Toxic substances: Anti-smokers often present a list of so-called "toxic" substances in tobacco smoke as proof that ambient tobacco smoke can be harmful to the nonsmoker.

28.

For example, cigarette smoke contains hydrogen cyanide. Anti-smokers may also say that ambient tobacco smoke includes "side stream" smoke (the smoke which goes directly into the air from the burning end of the cigarette) which has higher concentrations of some substances than the smoke inhaled by the smoker.

29.

These charges ignore the fact that first, the concentrations of these substances in ambient tobacco smoke are minute and, second, these substances are readily diffused in the air.

30.

Allergy: Anti-smokers often complain that many nonsmokers are allergic to tobacco smoke. ASH, for example, asserted in a recent submission to the Civil Aeronautics Board that as many as 30 to 34 million Americans "have a particular sensitivity to tobacco smoke."

31.

There is genuine question whether tobacco smoke has been shown to be or contain an allergen. Dr. Domingo Aviado, Professor of Pharmacology at the University of Pennsylvania Medical School and an internationally recognized expert, made the following statements:

32.

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...should a true tobacco smoke allergy be shown to exist, which has not been done, it would be quite rare. Estimates that large numbers of persons are allergic to tobacco smoke are unsupported by scientific data.

The method of determining whether an allergy exists has not been settled although many allergists make use of a skin test using tobacco leaf extract. Such skin testing is not at all comparable to exposure to tobacco smoke.

There is a major scientific difference between an allergy and an annoyance or an irritation. Individuals may be irritated or annoyed by a wide variety of airborne substances but not necessarily allergic to them.

What about ~~asthma~~? There is no objective scientific evidence to support the claim that ambient cigarette smoke adversely affects the lung function of asthmatics. In a 1977 study by Pinn, Shephard and Silverman, asthmatics were exposed to cigarette smoke in a small test chamber. The researchers were unable to find any significant changes in their lung functions.

Carbon Monoxide: Another claim is that the carbon monoxide in tobacco smoke is poisonous, severely affects a person's "task performance" and can cause cardiovascular and respiratory diseases.

* ~~Numerous~~ studies have shown that carbon monoxide concentrations in enclosed areas resulting from cigarette smoking are very low and do not present an inhalation hazard to the nonsmoker. ~~These studies include~~ actual carbon monoxide measurements and studies of the physical reactions of non-smokers (e.g., Harke 1972).

Auto exhaust and industrial fumes are, by far, the major sources of carbon monoxide in the daily environment.

To support the claim that smoking can produce higher carbon monoxide concentrations, anti-smokers have cited a study involving smoking in an automobile. However, the volume of the car involved was only 73.8 cubic feet, which is equivalent to a cube with sides of 4.2 feet each, and all windows and vents were closed.

In 1977, the FAA considered a petition by anti-smoking groups requesting a rule prohibiting tobacco smoking on the flight deck. The contention was that exposure to relatively low levels of carbon monoxide causes substantial impairments to vital brain and nervous system functions. The FAA carefully considered several studies and ruled that the petition did not disclose adequate reasons to justify the rule it requested.

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It is interesting to note a few carbon monoxide equivalents. One automobile driven 12 1/2 miles emits more carbon monoxide than a 1.4-pack-per-day smoker contributes to the atmosphere in an entire year. A Washington, D.C., Council of Governments study found that cars and trucks account for 92 percent of the carbon monoxide released into that region's air. The FAA measurements of carbon monoxide emissions from one Boeing 707 in its 33 minute landing-takeoff cycle is 202 pounds, the same amount as emitted from smoking 1.3 million cigarettes.

Nicotine: In 1975, two Harvard investigators, Hinds and First, measured the concentrations of nicotine in public places in Boston, such as restaurants and cocktail lounges. They demonstrated that in "public places nonsmokers could potentially consume 1/1,000 to 1/100 of one filter cigarette per hour, a level of exposure that has had no known serious association with disease."

In other words, for a nonsmoker to inhale the equivalent of one filter cigarette from ambient tobacco smoke he would have to spend from 100 to 1,000 continuous hours in a smoke-filled bar.

Nonsmokers With Compromised Health: Anti-smokers often argue that exposure to tobacco smoke causes stress to persons with severely compromised cardiovascular systems.

Because a delicate condition is presumed, it is impossible to establish a "no effect" level of carbon monoxide exposure for these persons, and there is some evidence that they may be adversely affected to some degree by any exposure sufficient to raise the carbon monoxide blood level.

This situation is indeed unfortunate. However, reference to this category of people as a reason for prohibiting smoking in public places ignores the fact that they may be subjected to discomfort and stress in the course of their normal daily encounters with carbon monoxide from automobile exhaust fumes and other air pollution. It has been stated that the only adequate protection for these persons would be to maintain them in an "oxygen-enriched" environment.

THE NON-PROBLEM

A study of cigarette smoking in aircraft conducted jointly by HEW, the FAA and the Department of Transportation concluded that the inhalation of ambient tobacco smoke aboard commercial aircraft "does not represent a significant health hazard to nonsmoking passengers." The result of the study was first announced in 1970, prior to the time of Surgeon General Steinfeld's statement that evidence showed ambient tobacco smoke could be harmful to nonsmokers.

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The ICC held extensive hearings in 1970 on smoking in buses. Although the ICC decided to segregate smokers on the basis of annoyance, it found that the asserted deleterious effects of second-hand smoke upon the health of motor bus passengers had not been adequately demonstrated.

47.

Dr. Edwin R. Fisher, Professor of Pathology at the University of Pittsburgh and Director of Laboratories at the Shadyside Hospital in Pittsburgh, said in October, 1977 that a careful review of research literature failed to support the conclusion that ambient tobacco smoke represented a health hazard to nonsmokers. Dr. Fisher said:

48.

The few studies that might appear to be contrary to this conclusion can, in my view, be rather readily dismissed for reasons of improper experimental design and lack of practical significance. For example, some studies use unrealistic quantities of smoke or fail to consider other sources of the agents being studied.

Even several eminent researchers and government officials who are well known for their opposition to tobacco use agree that public smoking is not harmful. Dr. Gio Gori of the National Cancer Institute said, "If we want to remain with facts and not with fiction, there is little danger of disease to people that stay in a room where people smoke."

49.

Dr. Reginald Stallones, an advisor to the Surgeon General's Advisory Committee on Smoking and Health, recently said, "In very direct terms there is no medical proof that non-smokers exposed to cigarette smoke in ordinary relation with smokers suffer any damage."

50.

Dr. E. Cuyler Hammond, vice president, Epidemiology and Statistical Research, of the American Cancer Society and author of famous studies linking smoking and lung cancer, was reported to have made statements to the International Conference on Public Education About Cancer in 1974 as follows:

51.

Dr. Hammond stated that there was "no shred of evidence that a non-smoker can get cancer from 'second hand' smoke and there is a lot of evidence that he cannot...." He added that to suggest passive smoking (inhalation of smoke by non-smokers) could cause cancer is dishonest, and that he would be prepared to testify as such in court.

It is apparent that anti-smokers' claims that nonsmokers are subject to injury by ambient tobacco smoke are not supported by scientific evidence.

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CHECKLIST OF ARGUMENTS

The following suggestions are intended to be guides for writing or speaking in response to anti-smoking arguments on public smoking actions. It is important to remember that health or scientific arguments can be ineffective in communicating with the general public. On the other hand, most people can clearly identify with arguments based on freedom of choice, and many people feel strongly that the "hand of government" should not interfere with their private lives.

53.

Restricting smoking in business establishments should be up to the proprietor.

54.

Every restaurant, hotel, and other public establishment is presently free to establish no smoking areas if this is the desire of patrons. It should be the proprietor's choice based on customer demand and "the marketplace."

The fact is that a majority of public establishments do not have no smoking sections. A survey by the National Restaurant Association confirmed that few members of the public actually desire separate sections for smokers and nonsmokers.

"The public smoking issue" can be resolved on the basis of common courtesy.

55.

• Most smokers will show respect for the wishes of those around them.

Public smoking laws present grave enforcement problems.

56.

During the prohibition era this country learned of the great difficulty government has in enforcing matters of social morality and conduct. Unless the police go on rounds to arrest an individual as soon as the person lights up in a no smoking area, it will be practically impossible to enforce public smoking laws effectively.

To the extent that shop owners and other proprietors are expected to be enforcers of these laws, they will be subject to difficult dilemmas. If a smoker lights up in a no smoking section, can the owner of a restaurant ask the person to extinguish the cigarette without risking the loss of patronage?

In light of serious U.S. crime problems, it is foolish to take police away from critical duties to determine whether a cigarette has been lighted in a no smoking zone. Yet if such laws are not

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vigorously enforced, their flagrant violation can breed further disrespect for the law.

How can anyone justify the cost of enforcing public smoking laws?

57.

Taxpayers are usually not aware of the high cost of restrictive ordinances. For example, it was reported that a San Diego public smoking ordinance cost taxpayers \$20,000 merely to get the law on the books in January, 1975. Complaints to the Police Department there cost over \$70 each for the officer's time, processing, paper work and court action.

Public smoking laws will place a substantial burden on individual proprietors and on the economy.

58.

This is particularly true when public smoking laws require the erection of physical barricades, improvements of the air circulation system, and other capital expenditures. The costs of compliance with such laws can be substantial. In addition, many establishments may be so small that they cannot effectively segregate smokers and nonsmokers.

A restaurant's economic success depends on maximum peak-hour traffic. Restricting the use of small areas at that time can cause losses.

Customers also can become irritated. For example, a smoker arriving to find a line waiting for the smoking section, when the no smoking section is empty, may be understandably angry. Whenever a patron is turned away, the proprietor risks losing that customer's business forever.

Efforts to attract conventions would be dampened by the risk that conventioners could be fined or jailed for lighting up in the wrong location.

Should an individual's smoking in public be criminally restricted by government actions?

59.

Is jail really the appropriate place for an individual whose "crime" is lighting a cigarette?

How far will government go to restrict our private lives?

60.

There are obviously many public annoyances to everyone in their daily lives. The "bad" or conflicting behavior and manners of other people in public places can cause substantial

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irritation. The noise and fumes of heavy traffic, the dissatisfaction toward public services like sanitation and law enforcement, the irritation from dirty streets, barking dogs, noisy neighbors or even the weather can certainly be more severe than the diffused smell of tobacco smoke in a ventilated public place.

Should laws also be passed to ensure good manners and behavior, and, if so, by whose standards? Any effort to extend government regulation into these areas would result in a massive interference with an individual's personal life and freedoms.

The public smoking issue may be best summarized by an editorial appearing in the Boulder Camera, (Boulder, Colorado, January 22, 1975):

It's one thing to legislate conduct for the protection of society--to restrict behavior that endangers the life, health or safety of others. It is quite another to legislate against conduct that merely annoys. Hardly anybody can avoid annoying somebody else occasionally. When government gets one foot into the realm of behavior modification, the blue-law thicket looms ahead.

Smokers' wishes should be respected, too.

The question of segregating smokers is really a matter of balancing the convenience and preference of smokers and nonsmokers. Although nonsmokers certainly have interests that must be considered, smokers also should be accommodated. The best and most effective method of balancing those desires and interests is through common courtesy on both sides, without the imposition of rigid and unworkable government requirements.

This nation does itself no service when unnecessary social conflict arises from the advocacy of misstated and erroneous health concerns.

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QUESTIONS & ANSWERS

Individuals associated with the tobacco industry often are confronted by thought-provoking questions regarding smoking and health, public smoking and other issues which make up the controversy surrounding the industry. In the past, employees have not been adequately equipped to deal with these questions. Brown & Williamson prepared this handbook in an effort to inform employees with a depth of knowledge surrounding the issues.

The following section includes a series of questions and answers covering a variety of issues. These questions have been accumulated from media interviews and discussions with a variety of groups by Brown & Williamson and industry spokespersons. The following questions and answers are not intended to make "spokespersons" out of Brown & Williamson employees, but they are intended to better inform our managers.

Q: Does smoking cause lung cancer, emphysema, cardiovascular disease and bronchitis?

A: No one knows. Scientific research has not established that smoking causes illness. We all know some scientists have said smoking causes illness, but many respected scientists believe cause has not been shown. More research is needed.

Q: How can you deny the overwhelming statistical evidence that smoking causes disease?

A: The case against smoking is based almost entirely on inferences from statistics. But most scientists will agree that statistical associations cannot establish cause and effect. Statistical associations are only clues which show the need for clinical and laboratory experiments. There are other flaws in the statistical arguments, such as the reliability of the data. By the way, there is a statistical association between lung cancer and the use of electric razors. We need more biological research.

Q: When you look at lungs taken from smokers and nonsmokers, it's obvious that smoking has damaged the lungs of the smoker, as compared to the lungs of the nonsmoker. This proves that smokers are damaging their lungs.

A: Perhaps you've seen the rather grisly exhibit set up by the American Cancer Society which contains two specimens of lung tissue, one which is smooth with a light cream color and the other which has warts and is coal black. One lung is said to be from a smoker and the other from a nonsmoker. You can guess which is which. The exhibit is deceptive because it represents that the differences in the tissues are typical results of smoking. This is not true. A former president of the College of American

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Pathologists testified before a Congressional Committee that: "I have examined thousands of lungs both grossly and microscopically. I cannot tell you from examining a lung whether or not its former host had smoked....I state flatly and unequivocally and emphatically that cigarette smoking will not turn the lung black."

Q: Do you deny that smoking is hazardous to your health?

6.

A: No one knows. Many respected scientists believe that a causal relationship between cigarette smoking and illness has not been proven.

Q: Do you claim that the benefits of smoking outweigh the risks?

7.

A: Whether or not to smoke is a choice to be made by informed adults based on individual assessments. Obviously many people derive some value from smoking because it has been a popular custom for hundreds of years. Columbus found the American Indians smoking, and sales of tobacco leaf supported the Jamestown Colony.

Q: How can you smoke when you know you are causing health problems to nonsmokers in the same room?

8.

A: Smoke in the ambient air is not harmful to the health of the nonsmoker. Even medical experts who have been associated with the charge that smoking causes lung cancer in the smoker have said that smoke in the ambient air has no influence on the health of the nonsmoker.

Q: Why are manufacturers producing more low "tar" and nicotine cigarettes and advertising those brands heavily if there is no health risk involved in smoking high "tar" and nicotine cigarettes?

9.

A: Cigarette manufacturers are producing low "tar" and nicotine cigarettes in response to consumer demands for those products. Your perception of the growth of the low "tar" segment is correct. Sales of cigarettes with less than 15 milligrams "tar" content increased by more than 50 percent in 1976 and comprised roughly 25 percent of the total cigarette market in 1977. Only a few years ago low "tar" and nicotine cigarettes were an insignificant part of the market. This very rapid shift shows the cigarette manufacturers' eagerness to respond to customers' changing preferences. The advertising emphasis simply follows the shift in consumer demand. No cigarette manufacturer has said there is no health risk involved in smoking high "tar" and nicotine brands. As with the question of smoking and disease in general, no one knows.

Q: How much money does the tobacco industry spend each year in advertising to attract new smokers?

10.

A: None. Cigarette advertising is brand advertising. Its purpose is competition against other brands for consumers, not to attract new smokers.

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- Q: Nine out of ten smokers say they want to quit. Shouldn't the government help them by sponsoring quit-smoking programs? 11.
- A: Each adult individual must make up his own mind whether to smoke. The tobacco industry is not interested in preventing anyone from giving up cigarettes. Many private stop-smoking programs are available at little cost, and literature which describes ways to stop smoking is available from several sources. Many people have stopped without a formal program. It is not necessary to spend taxpayers' money.
- Q: Doesn't the cigarette industry feel some responsibility for the \$8 billion cost to the United States for health care and \$18 billion cost to the United States in loss of production time caused by cigarettes sold? 12.
- A: The charge is based on the assumption that smoking causes illness, but causation has not been established by scientific research. There are other difficulties with the figures. For example, the figures assume the need for health services included would disappear if no one smoked cigarettes. With our aging population, this is unlikely.
- Q: Doesn't the nonsmoking majority in this country have the right to vote that cigarettes should not be smoked in public places? 13.
- A: No! Such a law would be completely unjustified as a function of government in our society. Tolerance is the cornerstone of this country's democracy. There is no health danger to nonsmokers -- the problem is annoyance. This is a social matter which must be left to people to resolve in social situations through mutual courtesy. Laws dictating personal social conduct, arrests, fines, and forced segregation are inappropriate means of dealing with a social situation. If there are going to be laws prohibiting smoking in public places, there should certainly be laws prohibiting strong perfume, body odor, and untrained pets.
- Q: What would you tell your child if he asked you whether he should smoke cigarettes? 14.
- A: I would tell him to wait until he was an adult and then make up his own mind. Whether to smoke is a choice for the individual and a choice that should be made only by informed adults.
- Q: How do you account for the fact that so many government and scientific societies have passed resolutions asserting that smoking causes lung cancer and other human diseases? 15.

A: The fact that government bodies and scientific societies have passed such resolutions indicates that the continuing controversy over smoking and health is political, not scientific. Scientific issues in the medical field are settled by definitive biological experimentation, not by the passage of a resolution. There have been no experiments proving that cigarette smoking causes illness, and that is why activists in government agencies and scientific organizations have resorted to resolutions to establish their personal opinions.

Q: Don't all of the medical experts in the United States agree that smoking causes lung cancer?

16.

A: As a matter of fact, many scientists in the United States hold the view that smoking has not been scientifically established as a cause of lung cancer. They note that no one knows the cause or causes of lung cancer. Nor does anyone know the mechanism or mechanisms whereby this disease develops.

Q: Won't you concede that smoking is a prime suspect as a cause of lung cancer?

17.

A: Scientists generally agree that lung cancer is a multifactorial disease, i.e., it has been statistically associated with many factors. These include occupation, geographical location, sex, urbanization and several others as well as smoking. But factor does not mean cause. Whether any of these suspects plays a role in the causation of this disease is as yet unknown.

Q: Aren't there cancer-causing agents in tobacco smoke? Don't they explain the association between smoking and lung cancer?

18.

A: For more than 20 years now, cancer researchers have been trying to identify components in tobacco smoke that are harmful to human health. To date, however, they have not identified any ingredient or group of ingredients, as found in tobacco smoke, that are disease-producing in humans.

Q: Doesn't tobacco "tar" produce cancer in animals?

19.

A: Contrary to popular belief, human smokers are not exposed to tobacco smoke condensate -- commonly referred to as "tar." Tobacco "tar" is a laboratory product that is produced by passing tobacco smoke through a cold trap at an extremely low temperature -- a temperature that human smokers simply do not experience. Hence, the relevance of animal experiments with tobacco "tar" is dubious. And it should be remembered that, despite great efforts by many scientists, human-type lung cancers have not been produced in laboratory animals as a result of exposure to tobacco smoke.

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- Q: Hasn't lung cancer in women begun to increase as they have begun to smoke more? 20.
- A: There has long been a wide gap between the incidence of lung cancer in males and females and this gap has not been satisfactorily explained in terms of smoking. As to the recent reports of increased cancer in women, some scientists believe that this disease has been increasing in women for many years, which is not consistent with a smoking-causation hypothesis. There are other considerations. For example, the lung cancer increase reported in women is usually of a different type from those reported as predominant in men and, in fact, is a type not generally considered associated with smoking.
- Q: Isn't nicotine known to cause disease in humans? 21.
- A: In 1964, after reviewing the then existing literature, the Advisory Committee to the U.S. Surgeon General concluded that the small amount of nicotine absorbed by tobacco use "probably does not represent an important health hazard" to humans. Since 1964 there has been no scientific evidence which would warrant a change in this conclusion.
- Q: What about heart disease? Isn't it pretty well established that smoking causes this disease? 22.
- A: Heart disease is a multifactorial disease, i.e., one which has been statistically associated with many factors. So far, more than 20 factors have been identified. Factor does not mean cause. No one knows whether any of the observed factors plays a role in the causation of the disease. Recent studies of identical twins suggest that a person's genetic background may be the most important factor. Other studies indicate that a person's personality type is the prime factor.
- Q: What about people who are allergic to tobacco smoke? How can they protect themselves from smoke in the atmosphere? 23.
- A: Although many people talk about tobacco allergy, it has never been established that tobacco smoke allergy exists. Scientists simply do not know whether or not tobacco smoke -- as opposed to tobacco leaf -- contains allergenic components.
- Q: Aren't cigarettes addictive? 24.
- A: It is difficult to discuss addiction today because people apply the term to many different circumstances. Some people say they are addicted to chocolate; others say their children are addicted to TV. The 1964 Surgeon General's report concluded that cigarettes

should be classified as habituating, like coffee, and not addictive, like morphine. Many people have given up smoking. Why do some people continue to smoke who say they want to quit? Why do people continue to overeat when they say they are too fat?

Q: Isn't modern cigarette advertising an improper business practice because it has a heavy impact on children and leads them to smoke?

25.

A: Cigarette advertising is intended for adults only. For example, cigarette advertisements show no models who are under 25 years of age, no entertainment celebrities and no athletes. Cigarette advertising can establish brand loyalty -- and that is its purpose -- but it does not attract new smokers. No studies have shown that cigarette advertising causes children to smoke. Dr. Ernest L. Wynder, president of The American Health Foundation, said he did not believe cigarette advertising had much influence on smoking.

Q: What questions were left unanswered by the 1964 Surgeon General's report?

26.

A: Many questions were left unresolved. Why, for example, do nonsmokers fall victim to heart disease, lung cancer and other diseases frequently associated with smokers? If, as some anti-smoking groups claim, cigarette smoking is the major cause of lung cancer, why is it that the vast majority of the "heavy" smokers never develop the disease? Why hasn't independent scientific research been able to identify any one or combination of the thousands of components as found in cigarette smoke as the cause of any particular disease? Why in more than forty years of research hasn't anyone been able to reproduce the type of lung cancer associated with smoking--through tobacco smoke inhalation--in laboratory animals?

Q: Will the anti-smoking movement succeed?

27.

A: The anti-smoking movement is actually proposing prohibition. According to Dr. Peter Bourne, Special Assistant to the President for Health Issues, such proposals are not realistic. In remarks to the Ad Hoc Committee on Tobacco and Smoking Research of the American Cancer Society on November 10, 1977, Dr. Bourne said, "Because of the political, social and economic ramifications, it is unrealistic for us to suggest a tobacco prohibition as a feasible short-term goal, and that campaign would bring into question our own credibility. It is there that we are on our weakest ground. While prohibiting use of cigarettes in public places would please nonsmokers, it would not necessarily reduce overall cigarette consumption or reduce the health consequences. We have done little research on the hazards, if any, of other people's cigarettes."

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Q: What is the tobacco industry doing to help resolve the smoking and health controversy?

28.

A: In the last 24 years the tobacco industry has provided more than \$70 million for independent research regarding questions related to smoking and health. In many of these years this commitment has exceeded that of any government department, and has been substantially more than the research expenditure reported by all the voluntary health associations, who spend a major portion of their donated funds for administration and for public relations campaigns. The tobacco industry is committed to advancing scientific inquiry in this area.

Q: Do the tobacco companies control the research they sponsor?

29.

A: Absolutely not! The commitment of the tobacco manufacturers to resolve the smoking and health controversy has never been fully appreciated. Grants are made with no strings attached except a pledge to apply the money to legitimate scientific research. Each researcher is free to publish his study results, whatever they may be.

Q: Does it bother your conscience to sell cigarettes?

30.

A: Absolutely not! The tobacco industry is a \$15 billion industry affecting 17 million people. As far as the health question is concerned, no valid research has ever established that cigarette smoking causes illness. Nevertheless, every pack of cigarettes carries a warning label as required by law. A person would have to be a "cave dweller" not to be aware of the warning. We live and work in a country which supports the free enterprise system. It gives its citizens the freedom of choice. We should continue to enjoy that freedom both in our business and in our personal lives.

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SMOKING AND HEALTH

THE OPEN QUESTION

For many years, certain individuals and organizations have claimed that smoking causes a large number of diseases. Such claims are largely based on studies which have reported statistical associations between smoking and various diseases.

However, such associations alone can never establish cause-and-effect relationships. The most that such data can do is to indicate areas for further scientific research. Unfortunately, scientific data that contradict the popularly-held belief that smoking causes disease are generally ignored or severely criticized without adequate justification.

It has become easier to indict smoking as the sole source of our medical problems than to confront the data which show an existing scientific controversy and the need for further well-defined objective research to establish the facts. The following discussion will highlight some of the topics mentioned above.

SMOKING AND LUNG CANCER

The evidence cited to implicate cigarette smoking as a cause of lung cancer has been provided primarily by statistical studies, such as the Hammond and Horn survey of white American men in nine states. However, such studies have been seriously questioned. For example, in 1958, Dr. Joseph Berkson of Mayo Clinic observed that "Cancer is a biologic, not a statistical, problem." More recently, a British physician noted that "the cause of cancer of the lung is not known. We have only statistical inferences and forecasts.... Until it is discovered no one who values scientific evidence should assume that cigarettes cause cancer of the lung."

In 1977, a South African physician who reviewed some of the original statistical studies which are used to support the claim of a causal relationship discovered errors in the analyses of the data. As a result of these discoveries and other observations, he concluded that "The smoking hypothesis has received emphasis which it really does not deserve." He added that "This hypothesis has to be abandoned."

One of the most pertinent facts to be kept in mind when claims about smoking and lung cancer are considered is that some reported statistical data are not consistent with the causal hypothesis. For example, researchers have reported large variations in lung cancer mortality rates in a number of countries which cannot be explained by differences in

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tobacco consumption. Austria, Belgium and Finland report higher lung cancer rates but considerably lower per capita tobacco consumption than the United States, Canada and Australia.

Lung cancer mortality rates may not be reliable because they are based on the often inaccurate information regarding cause of death as shown on death certificates. This conclusion is supported by the finding of researchers who compared clinicians' diagnoses of lung cancer with autopsy results and found serious discrepancies. Such errors may have resulted in part from the clinicians' difficulties in determining whether a cancer originated in the lung or had spread to the lung from another site.

The reported increase in lung cancer, said to be of "epidemic" proportions, may be greatly overestimated. Experts have suggested that the reported increase may be an artifact created largely by improved diagnostic techniques. The recent intense interest in lung cancer may also have resulted in an over-diagnosis of the disease.

Experiments in which laboratory animals are forced to inhale tobacco smoke have failed to prove the hypothesis that smoking causes lung cancer. Not only has the relevance of such experiments been questioned, these techniques have failed to produce in animals any lung tumors which are of the type associated with human smoking.

Much of the interest in the causation theory was generated by skin-painting experiments in which tumors were produced by painting "tar" (a laboratory product obtained by passing tobacco smoke through a cold trap at extremely low temperatures) on the shaved backs of animals. However, these experiments are inappropriate for comparison to the inhalation process of humans, for several reasons. The skin of an animal is not at all similar to human lung tissue. Furthermore, the application of a substance to the skin is quite different from inhalation. Finally, there is no "tar" as such in tobacco smoke, and even if there were, the quantities used in such experiments are unrealistic.

In an effort to determine why some people develop lung cancer while others do not, a number of scientists are studying the "constitutional hypothesis." This hypothesis states that some people who have a hereditary predisposition for lung cancer also have a hereditary tendency towards smoking. It is supported by research which shows that smokers differ from non-smokers in many physiological and psychological characteristics.

Occupational and environmental factors, such as air pollution, have also been found to be associated with lung cancer. Concern has been expressed that the concerted effort

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to prove that smoking is the primary cause of this disease may be diverting attention from such factors.

Any serious discussion of the claims linking smoking and lung cancer must include consideration of the following two facts:

1. Lung cancer was an established disease long before cigarette usage became popular.
2. Most smokers do not develop lung cancer, while many non-smokers do.

SMOKING AND CORONARY HEART DISEASE (CHD)

In efforts to determine the cause of coronary heart disease, researchers have examined a variety of behavioral, physiological and environmental factors which have been associated with an increased risk of this disease. Cigarette smoking is considered by some to be one of these so-called "risk factors."

For example, the 1976 Public Health Service Report on The Health Consequences of Smoking describes smoking as "one of the major independent CHD risk factors." However, available data do not provide consistent support for the identification of smoking as a risk factor. For example, an international study by Keys found "little or no" relationship between cigarette smoking and coronary heart disease in Finland, the Netherlands, Yugoslavia, Italy, Greece and Japan. Furthermore, several studies cited to support the role of smoking in the development of coronary heart disease contain data inconsistent with this claim. In one such study, coronary heart disease mortality rates actually were lower in ex-smokers than in nonsmokers.

Researchers also have studied a number of other factors which appear to be associated with an increased prevalence of this disease. For example, some scientists have observed specific behavior patterns that appear to be associated with an increased prevalence of CHD. This coronary-prone behavior pattern, called Type A, is characterized by such traits as aggressiveness, ambitiousness, time consciousness, and a chronic sense of urgency. Other scientists have concluded that there is a strong genetic component in the development of CHD. Studies of twins and familial coronary heart disease patterns have provided support for this theory.

The stresses normally encountered in daily life also have been positively associated with coronary heart disease. Researchers have found that severe financial problems, occupational tensions, and life-style changes have produced physiological alterations which may lead to coronary lesions. One

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investigator, who studied the mortality statistics of 100,000 physicians who reportedly had quit smoking, commented:

It is evident that there has been no increase in the average age of death among physicians during the past 16 years. . . . While it is possible that the full results of this abstinence (not smoking) have not yet been seen, the resolution of underlying stress rather than smoking per se may be the crucial factor. . . . These findings are consistent with the apparent predisposition of doctors to coronary heart disease, a vulnerability which can be attributed to the stresses in their way of life.

Therefore, the indictment of cigarette smoking as a major risk factor in coronary heart disease mortality is contradictory to such scientific fact.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Claims have been made that cigarette smoking causes COPD, a term which refers primarily to chronic bronchitis and pulmonary emphysema. Such a claim was made in the most recent report on smoking by the Royal College of Physicians of London called "Smoking or Health."

However, these claims are contradicted by statements of scientists and governmental officials who note that the cause or causes of these chronic lung diseases are still unknown. For example, a special report supplied by the Department of Health, Education and Welfare for use during consideration of its 1979 budget request indicates that "the exact cause of emphysema is not known"

Such statements are supported by an examination of cigarette consumption patterns which exhibit no consistent relationship with COPD incidence rates and mortality trends. This is illustrated by the fact that individuals who have never smoked develop COPD but many smokers do not. Moreover, large international variations in COPD mortality rates cannot be explained by levels of tobacco use.

Certain animal inhalation studies have been cited as proof that smoking causes COPD. However, serious questions have been raised about the adequacy of the experimental techniques employed and the relevance of the results to man. For example, numerous structural differences identified in the respiratory systems of mammals may complicate the extrapolation of animal test results to the human situation.

Some researchers who have examined the reported increase of COPD in cigarette smokers speculate that it may be

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the result of basic psychological and/or physiological differences between smokers and nonsmokers. For example, even when smoking habits are similar, blacks seem to have a lower incidence of chronic bronchitis and emphysema than whites.

Occupational exposures may also play an important role in the development of COPD. A scientist familiar with occupational exposures recently wrote that the available evidence does not support claims that smoking is the major hazard to workers' lungs; he concluded, "... it's their jobs which seem to cause their illness."

In recent years, ambient air pollution has received increasing attention as a major cause of COPD. Lave and Seskin have concluded that "mortality from bronchitis would be reduced by about 50% if air pollution were lowered to levels currently prevailing in urban areas with relatively clean air." They continue:

The studies document a strong relationship between all respiratory disease and air pollution. It seems likely that 25% of all morbidity and mortality due to respiratory disease could be saved by a 50% abatement in air pollution levels.

Therefore, claims that smoking causes COPD must be seriously considered in light of this evidence.

SMOKING AND PREGNANCY

Claims have been made that smoking during pregnancy causes adverse effects, in particular that smokers are more likely to have low-birth-weight (LBW) infants. Some claims have even been made that smoking increases the risk of congenital malformation and perinatal mortality. However, these claims are based on statistical data which are at best equivocal and, furthermore, cannot prove causal relationships. Moreover, there are data which are inconsistent with certain of these claims.

Low-Birth-Weight Infants. A biostatistician who examined and was unable to accept the causal hypothesis contended that the data he studied may suggest the existence of some other common factor which causes women both to smoke and to have a higher proportion of LBW infants. Yerushalmy advanced this theory in a 1972 report describing data which, he later said, "almost clinch the argument against causation:"

This conclusion follows from the finding that women who eventually became smokers produced a large proportion of low birth weight infants even before they started to smoke. . . .

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To explain these findings, Yerushalmy speculated that the higher incidence of LBW infants among smoking women may be due to the smoker, rather than the smoking.

Yerushalmy's finding are supported by the results of other research projects, including two studies in which the researchers concluded that smoking apparently does not cause LBW but may serve as "an indicator" or "an index" of some other factor or factors that may be involved.

The need for further research on the relationship between maternal smoking and LBW was recognized by Silverman in a report on her study which had been designed to determine whether smoking causes LBW, or whether smokers are "a self-selected group that differs from nonsmokers in ways unrelated to smoking. . . ." Although she wrote that her findings were not conclusive, she observed that "The direction of the observed differences in mean birth weights is more consistent with the self-selection hypothesis."

Although these studies have failed to disprove either the causal or self-selection hypotheses, several have shown that smokers' LBW infants appear to be healthier than non-smokers'. Yerushalmy, for example, noted that LBW infants of smokers "are much healthier" than those of the nonsmokers and that the "healthiest" low-weight babies were born to couples in which the wife smoked and the husband did not.

Increased Perinatal Mortality. Scientific evidence does not support the claim that maternal smoking during pregnancy is causally associated with increased perinatal mortality. Several large studies, including those by Yerushalmy, Underwood, The Ontario Perinatal Mortality Study Committee, Rantakallio, and Targett have found no increase in the perinatal mortality rate of infants of smoking mothers. As the National Academy of Sciences Committee on Maternal Nutrition concluded in 1970, ". . . smoking is not significantly associated with excess fetal or neonatal mortality. . . ."

Congenital Malformation. Several large-scale population studies also have failed to establish a relationship between smoking and congenital malformation.

In a study of 51,490 pregnancies, for example, the Ontario Perinatal Mortality Study Commission found "no evidence that smoking was associated with a higher incidence of congenital malformations." Yerushalmy and Hollingsworth both reported that their studies showed that the risk of congenital malformation in LBW infants was lower for smoking than for nonsmoking mothers.

The available scientific evidence does not warrant the conclusion that a causal relationship between smoking, LBW, increased perinatal mortality and congenital malformation has been proven.

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CIGARETTE SMOKE COMPONENTS

Despite much repetition of the claim that certain substances in tobacco smoke are harmful to the smoker, it has not been scientifically proven that any component or combination of components as found in tobacco smoke causes disease.

These claims, which focus primarily on "tar," nicotine and carbon monoxide (CO), have led to proposals for establishing maximum levels of such substances in tobacco smoke. Such a recommendation currently is being considered by the Department of Health, Education and Welfare as part of a major anti-smoking initiative launched by Secretary Joseph Califano.

The following discussion describes some of the inadequacies of the scientific evidence for the claimed health effects of these three substances.

"Tar." There is no "tar" as such in cigarette smoke. The substance called "tar" is actually a laboratory product obtained by collecting the particulate matter in tobacco smoke. This hardly simulates what humans are exposed to in the smoking process. That is why quotation marks are often used around the word "tar" when referring to tobacco smoke.

"Tar" is not smoke. There is no good reason to assume that any biological activity of whole smoke can be accurately determined by studying "tar." The chemical and physical changes necessarily brought about in condensing the smoke and applying the substance to animals may well produce biological results completely different from any that may occur during smoke inhalation.

Nicotine. Nicotine has historically received as much experimental attention as "tar." However, nicotine, in the amounts found in tobacco smoke, has not been scientifically established as hazardous to smokers. Even the 1964 Report to the Surgeon General on Smoking and Health concluded that nicotine as found in tobacco smoke "probably does not represent a significant health problem." After thirteen years of intensive research, no data have been developed which would warrant a change in that conclusion.

Nicotine has no known chronic or cumulative effects. It is rapidly absorbed and metabolized by the human body into other simpler substances which exhibit no established harmful pharmacological activity. According to the 1964 Report to the Surgeon General, "Nicotine is rapidly changed in the body to relatively inactive substances with low toxicity."

Despite these statements, some smoking opponents have claimed that nicotine causes cardiovascular disease. However,

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this claim was clearly contradicted in testimony by a government witness at the 1976 hearings on cigarette smoking and disease. Dr. Theodore Cooper, then Assistant Secretary for Health, Department of Health, Education and Welfare, indicated that he considered smoking a risk factor for cardiovascular disease, but not a cause:

Senator Hart: ...I would merely ask if cigarette smoking causes heart disease?

Dr. Cooper: No.

Senator Hart: It does not?

Dr. Cooper: No.

Carbon Monoxide. This tasteless, odorless gas is present in tobacco smoke, but it is also present in the air we breathe. The predominant man-made sources include the exhaust fumes of automobiles and emissions from industrial processes. Furthermore, carbon monoxide is a natural body constituent created by normal metabolism.

As with "tar" and nicotine, the experimental evidence regarding ~~severe~~ health effects of CO, as found in cigarette smoke, is at best inconsistent. Studies of humans who are consistently exposed to low doses of CO have reported no increase in the incidence of heart attack or circulatory abnormalities.

Possibly because experiments with humans have failed to prove their claims, anti-smoking advocates have emphasized the results of animal experiments by certain researchers. Yet when animal experimentation is examined as a whole, it also fails to provide consistent results on the effects of CO exposure. Moreover, the recent research findings of one of the scientists frequently cited as having demonstrated a link between carbon monoxide and heart disease did not confirm the conclusions about the effects of carbon monoxide drawn in his earlier studies.

Such evidence indicates that the claims made about the health effects of certain constituents of tobacco smoke on the smoker are just that--claims which are not established by scientific proof.

RESEARCH

The ~~scientific~~ commitment of the tobacco industry is clear. For nearly 25 years the cigarette manufacturers have been supporting totally independent research with completely non-restrictive funding. The results--whatever they are--may be published wherever the researcher chooses.

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Hundreds of researchers in medical schools, hospitals and other scientific institutions in this country and abroad have received more than \$70 million from the tobacco industry to support their investigations.

The findings of scientific studies funded in whole or part by the cigarette companies comprise more than 2,000 papers published in the world's professional literature.

The Council for Tobacco Research - U.S.A., Inc., an industry-sponsored agency, has the major responsibility for the evaluation and funding of research proposals. Research support has been implemented mainly through a program of grants-in-aid, supplemented by contracts for research with institutions and laboratories. The Council does not operate a research facility.

The position of the tobacco industry is that the questions raised by the smoking and health controversy can be resolved only by sound scientific research.

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RJR

Your suggestions about a
follow-up session to focus
on our information needs
and problems to be solved
are invited. DMF

XC: Dr. Laurene Dr. Colby
McQuarrie McQuarrie

Inter-office Memorandum

Subject: Nicotine Research DMF

Date: November 9, 1976

To: Dr. D. H. Piehl

From: W. M. Henley

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A summary of the major points developed during the October 25, 1976 discussion on nicotine is presented below. The primary goals of this discussion were: (a) to review our current knowledge concerning nicotine, (b) to discuss particular research needs in terms of problems to be solved and questions to be answered and (c) to establish, among staff personnel, a firmer base for stimulating dialogue and cross-fertilization of ideas in this area.

In evaluating progress toward the above goals, the author believes that the participants made excellent progress toward the first goal while progress toward the second goal, due to a lack of time, was very limited. As assessment of progress toward the third goal is much more speculative but is regarded as having been excellent. If this evaluation is reasonably accurate, then further discussions directed toward the second goal might be worthwhile.

Principal participants and their topics are noted below:

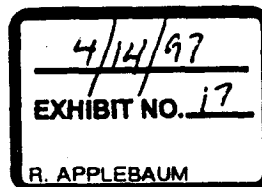
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|---|-----------------|
| 1. Physiological Action of Nicotine | R. F. Moates |
| 2. Smoking and Health Aspects | C. L. Neumann |
| 3. Taste of Nicotine | C. E. Rix |
| 4. Factors Influencing Presence in Leaf and Smoke | J. P. Dickerson |
| 5. Nicotine and Tobacco Substitutes | C. L. Neumann |
| 6. Nicotine Analogs and Mimics | C. L. Neumann |

Other participants were: A. Rodgman, R. L. Rowland, D. L. Roberts, D. H. Piehl, C. R. Green, R. A. Lloyd, M. E. Stowe, D. Lynn, R. E. Shackelford, W. M. Henley.

I. Physiological Action of Nicotine (R. F. Moates)

1. Site of Action

Nicotine interacts with cholinergic receptors at neural junction and thus initiates normal neural impulses. Those functions of the body which are normally under neural control by a steady-state normal rate of nerve impulses will thus be increased when nicotine reacts with these cholinergic nerve junctions. A nerve impulse is normally transmitted across a neural junction by the chemical acetylcholine. Nicotine is able to very effectively imitate the action of acetylcholine. Nicotine thus augments the stimulation of those tissues which have cholinergic receptors.



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The body functions which are controlled by cholinergic nerves are mostly parts of the autonomic nerve system. Included in these functions are the gastrointestinal tract (stomach, intestinal muscle contractions), heart rate control, peripheral blood vessel constriction and skeletal (postural) muscle control. The influence of nicotine on these functions leads to the following symptoms:

1. Elevated heart rate
2. Elevated coronary flow
3. Elevated blood sugar level
4. Lowered cutaneous temperature at extremities
5. Increased blood flow in skeletal muscles
6. Reactive release of adrenalin
7. Alteration of brain electrical potential pattern
8. Inhibition of patellar reflex

These last three symptoms are generally believed to be the results of nicotine's action on the central nervous system. Most studies of nicotine's effect on the CNS are not conclusive, due to the difficulty of isolating a single neural function known to originate in the brain. Furthermore, the brain is a mixture of cholinceptive and adrenoceptive receptors, of which nicotine affects only the cholinceptive receptors. Subjectively, however, nicotine is said to cause both mental arousal and relaxation.

2. Absorption, Metabolism and Excretion

Probably the most effective method of administering nicotine to the body is by inhalation of cigarette smoke. This is due to the fact that unionized nicotine is readily soluble in both hydrophilic and lipophilic solvents. About 60-90% of the nicotine in a puff of smoke is absorbed upon inhalation. The buffering action of oral and lung tissue, along with its large surface area, aid in the absorption of any nicotine bound in a salt form. Thus a high concentration of nicotine is suddenly produced in the pulmonary veins, which is then distributed to the brain and many parts of the body within a few seconds. Efforts to reproduce this concentration of blood nicotine by intravenous injection usually require about twice the amount of nicotine injected vs inhaled to produce a given physiological response. The responses most easily measured in both man and animals are heart rate and blood pressure.

The half-life of nicotine in the body is about 20-30 minutes. Nicotine in blood is readily excreted in urine and metabolized in the liver. Carbon-14 studies have shown that nicotine becomes concentrated in the brain about 5 minutes after injection. This study also illustrates nicotine's ready solubility in body tissues and ability to cross the blood-brain barrier. Nicotine is readily excreted in urine, especially as an acid salt. Urinary excretion of nicotine can be hastened if the urinary pH is lowered by ingestion of NH_4Cl . Conversely, excretion can be slowed if urinary pH is raised by ingestion of bicarbonate. Nicotine is readily detoxified in the liver by oxidation to cotinine. Most other nicotine metabolites are derived from cotinine by further oxidation and ring-opening of the pyrrolidone ring. The blood concentration of cotinine peaks about 2 hours after nicotine absorption, indicating the much slower metabolism and excretion of this compound.

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The physiological effects of cotinine are not known at this time, but are believed to be minor. Habituated smokers, both male and female, metabolize nicotine more rapidly than non-smokers, indicating the bodily metabolic acclimation to nicotine. However, male non-smokers excrete more cotinine and less nicotine than female non-smokers, indicating a sex-dependent metabolic difference in humans.

In contrast to the lung absorption of nicotine mentioned above, absorption through the mouth is very much slower and inefficient. The nicotine in cigar smoke (pH 8.5) is almost all unionized and readily absorbed by the oral membranes, if contact is made. But due to the slower absorption and transport, the concentration of blood nicotine achieved is never equivalent to that of lung absorption. The absorption of nicotine from an aqueous solution in the mouth is also pH dependent. The amount of free nicotine in a buffered solution held in the mouth thus determines the physiological response. Similar results are reported for nicotine absorbed from chewing gum. Also nicotine injected into other body tissues requires a 20-100 times larger quantity to produce similar physiological responses, again due to much slower transport within tissues.

II. Smoking and Health Aspects (C. L. Neumann)

Two basic schools of thought exist currently:

- A. Reduce both "tar" and nicotine to achieve safety
- B. Reduce "tar" and increase (or hold level) nicotine

Classic skin painting experiments have tacitly assumed nicotine to be harmless, as animals (mice) are usually conditioned to nicotine toxicity before time zero.

Wynder and Hoffmann report nicotine to be a very low level ciliostat: "Nicotine in the concentration present in cigarette smoke was not found to be ciliotoxic by Boche and Quilligan" (1959).

Bock has reported (1976 AACR meeting) low to moderate concentrations of nicotine act as a cocarcinogen stimulus when applied to mouse skin. During our discussion, the accuracy of the results of Bock (and of all the NCI skin painting studies) was questioned. Possibly an explanation of nicotine's promoter activity may be due to its ability to rapidly transport across the skin barrier, an effect not relevant in inhalation studies.

III. Taste of Nicotine (C. E. Rix)

Observations concerning the taste of aqueous nicotine are described below:

<u>Concentration</u>	<u>Taste Perception</u>
10^{-5} M (1.62 μ g/ml)	None
10^{-4} M	Some Taste (foul, rotten rubber) No Irritation
10^{-1} M	Definite Burning Irritation
10^{-1} M	1 μ l Puff: Strong Tongue Sting and Throat Grab

Sensitivity to nicotine occurs only on the front tip of the tongue.

Nicotine is definitely an irritant in smoke and its taste must be blended out or modified by other constituents in the TPM to make the smoke acceptable.

Propylene glycol and sucrose can reduce nicotine irritancy, but large amounts are necessary. "Neutralization" with acids also reduces irritancy somewhat and appears most promising as a taste modifier.

IV. Factors Influencing Presence in Leaf and Smoke (J. P. Dickerson)

Nicotine is produced in the root system of the tobacco plant. The amount of nicotine produced depends on genetics, climate and cultural practices. Burley tobacco generally contains more nicotine than flue-cured. However, geneticists have produced low-alkaloid burley varieties with nicotine contents as low as 0.2 percent. Similar flue-cured varieties are apparently not available. Experimental flue-cured varieties with high nicotine levels, ca. 6 percent, have been produced. Annual variations in nicotine content of burley and flue-cured tobaccos are primarily due to weather conditions. In dry weather the tobacco plant produces an extensive root system and as a result nicotine production increases. Excessive rainfall produces a smaller root system and also leaches nitrogen, which is necessary for nicotine production, from the soil. Fertilization and topping height are cultural factors which influence the amount of nicotine in tobacco. Nicotine production in the plant can be increased by increasing the amount of available nitrogen in the soil. Nicotine content is inversely related to topping height. As the number of leaves on the plant is reduced by lowering the topping height, the nicotine content of the plant increases. Therefore, a low topping height such as that employed in the low-profile harvest system results in a nicotine level which is greater than that of conventionally grown tobacco.

The nicotine content of RJR domestic purchases varies from year to year. The 1969 and 1970 burley crops were exceptionally high in nicotine. In 1971 the nicotine content of the burley tobacco dropped to one of the lowest levels that have been observed. During the 1971-1973 period both burley and flue-cured crops had low to average nicotine contents. The 1974-1976 flue-cured crops have been high in nicotine. Nicotine content of the flue-cured crops has increased each year since 1973. This increase has been due to lack of adequate rainfall. The burley crops have produced reasonable levels of nicotine since 1972. The nicotine content of the 1976 burley crop is not known at this time.

Nicotine content of both flue-cured and burley tobaccos varies with stalk position. Nicotine in the leaf and smoke increases from the bottom to the top of the stalk. FTC "tar" values follow the same pattern. The "tar"/nicotine ratios decrease from the bottom to the top of the stalk. The lowest "tar"/nicotine ratios are observed in the tobaccos with the highest "tar" deliveries.

Company flue-cured and burley grades show variations in leaf and smoke nicotine which are related to stalk position. The flue-cured "straight" grades, which come from the lower half of the tobacco stalk, give lower nicotine analyses than the "X" grades from the upper stalk positions. Variations between grades in the "straight" grades series are relatively small with nicotine in leaf and smoke

increasing slightly as quality increases. Larger differences between grades are observed in the "X" grades and nicotine decreases with increasing quality. The burley grades are divided into three groups according to stalk position. Within each group quality increases as nicotine increases.

The transfer of leaf nicotine to smoke appears to follow a pattern similar to that of smoke pH in both burley and flue-cured tobaccos. In the burley tobacco both nicotine transfer and smoke pH increase with increasing height of the leaf on the tobacco plant. In flue-cured tobacco, both of these characteristics decrease from the bottom of the plant to mid-stalk and then begin to increase. Nicotine transfer in flue-cured is roughly inversely proportional to sugar content.

The major portion of nicotine in the smoke of WINSTON comes from flue-cured and burley tobaccos. Preliminary data from a study of WINSTON blend components indicate that Turkish tobacco and 6-7 are responsible for less than 20 percent of the nicotine delivery of WINSTON blend. Flue-cured tobacco contributes around 60 percent of the smoke nicotine and the remaining nicotine comes from burley tobacco. The flue-cured appears to contribute more nicotine per gram of tobacco than the burley. This is due to the denicotinization of burley and the use of casing. In addition, nicotine content of the flue-cured which is used in current blends is relatively high. Additional studies of the relationship between nicotine delivery of WINSTON blend and nicotine delivery of individual blend components are in progress.

The Kool blend contains the most nicotine of the four major competitive brands (WINSTON, SALEM, Marlboro). Marlboro contains the least. Nicotine deliveries of Kool, SALEM and WINSTON have fluctuated between 1.2 and 1.4 mg for the past two years. The Marlboro delivery has been consistently lower during this period. Philip Morris has maintained a relatively constant nicotine delivery of around 1.1 mg in the Marlboro for the past two years. The relatively low nicotine delivery of Marlboro is partially due to the filter and rod characteristics of this cigarette. The pressure drop of the Marlboro rod is lower than that of WINSTON and the filter pressure drop is higher. The Marlboro filter is more efficient than that of WINSTON. An 85 mm filter cigarette from WINSTON blend with the Marlboro filter and tobacco rod characteristics delivers less "tar" and nicotine than WINSTON.

The transfer of leaf nicotine to smoke is lower in Marlboro than in WINSTON. The difference between the two blends is partially due to blend characteristics of the Marlboro which have not yet been defined.

Literature reports indicate that as smoke pH increases the efficiency of nicotine filtration of cellulose acetate filters increases. In-house experiments indicate that this is not the case.

Sugar in burley casing reduces the nicotine delivery. A response surface (RSM) study which is designed to define the relationship between casing and nicotine delivery is in progress.

Additional information concerning nicotine in Company tobaccos and competitive brands is available in formal reports. RDR, 1976, No. 14 reports cited therein describe the relationship between Company flue-cured grades and nicotine delivery for the 1972-1975 period. RDM, 1976, No. 16 contains competitive brand data for

1975. A review of in-house nicotine data is reported in RDR, 1975, No. 9.

V. Nicotine and Tobacco Substitutes (C. L. Neumann)

1. Sutton I Material and Nicotine Delivery

Original RJR notebook data showed two things for nicotine transfer in Sutton I material, first that mixtures of tobacco and Sutton I material did not transfer nicotine in proportion to the tobacco content, but rather, the expected amount was decreased as Sutton material increased. Secondly, nicotine or its salts added to Sutton material transferred to mainstream smoke at a rate about half that found for tobacco (9% vs 17-19%).

2. Current Substitutes and Nicotine Delivery

Extrapolating the data above to other substitutes such as Cytrel, MSM, J-10, we may reason that they will transfer nicotine to smoke in a tobacco-like manner, as the available data shows that mixtures of these substitutes with tobacco have smoke nicotine levels proportional to tobacco content.

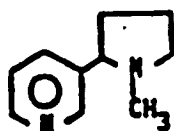
3. Inert Extenders, G-7L and Nicotine Delivery

Tobacco incorporating inert extenders (CaCO_3) transfer nicotine much like tobacco, at a % transfer rate of ca. 17%; G-7L material transfers nicotine at a somewhat lower percent (14%). Both rates are corrected for cigarette burn rate.

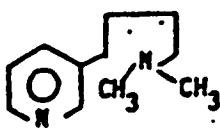
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VI. Nicotine Analogs and Mimics (C. L. Neumann)

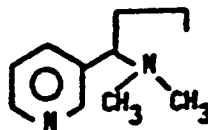
Standard relative activity on frog rectus muscle preparations:



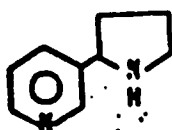
F = 1.0



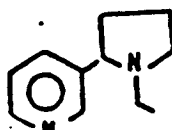
F = 0.2



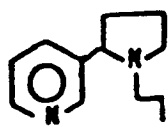
F = 0.00



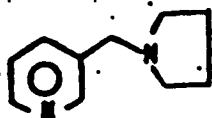
F = 0.5



F = 0.07

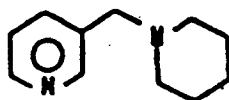


F = 0.015

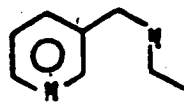


F = 0.3

resembles nicotine
in mode of action

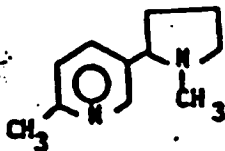


F = 0.2

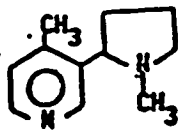


F = 0.00

and also standard relative activity on Guinea pig ileum (nicotine = 1.0):



G = 1.25



G = 0.00

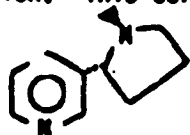
N-acetyl normicotine is reported to have ca. 1/12 the activity of N-ethyl normicotine.

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Conformational studies and x-ray diffraction show nicotine to have the following conformation. This correlates with most data.



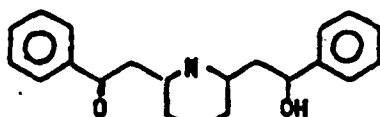
Natural nicotine mimics are relatively abundant in nature. Those below show nicotine-like activity. They have widely varying activity levels and toxicity levels, however.

Nicotine: found in Nicotiana species, Duboisia hopwoodii, Lycopodium species, Equisetum arvense, Mucuna pruriens

Anabasine: in Nicotiana, Anabasis aphylla, Chenopodiaceae

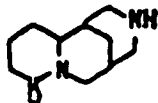
Nornicotine*: in Nicotiana, Duboisia hopwoodii (d and l forms)

Lobeline



d - form active only,
also dialcohol and diketone
active

Cytisine



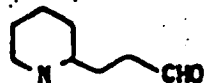
Conine (coniine)



from hemlock

120 mg fatal to man
.5 mg/kg = active dose

Pelletierine



from rootbark of pomegranate tree

Sparteine



from yellow and black lupin beans

*d-nornicotine is reported to be 2.5X toxic as nicotine to rats

†note that this means a 240 lb man has active and fatal dose equal

Considering the wide abundance of nicotinic drugs, tobacco has assumed a very unique role in society. I do not think the ramifications of nicotine being classed as a drug by FDA and other (foreign) agencies should be overlooked.

VII. What We Need to Know About Nicotine

Due to a time limitation, this topic received virtually no attention. Several important questions were raised, however.

C. R. Green and D. Lynn raised the questions concerning the minimum level of nicotine required for smoker satisfaction.

R. L. Rowland asked if every possible variable had been investigated for its effect upon nicotine delivery to the smoker. It may be generally accepted that the delivery of nicotine is changed by changing the type of tobacco leaf which is used in the cigarette. But, holding constant the tobacco which makes up the cigarette, are we cognizant of all other factors in cigarette manufacture which would change the nicotine delivery, particularly any factors which would allow a decrease in tar delivery without the accompanying proportional decrease in nicotine delivery.

C. R. Green asked if nicotine in smoke was "free" or "bound" or some mixture of these two forms.

Also, the question was raised if some physical response could be measured to determine nicotine effect or satisfaction.

W. M. Henley
W. M. Henley

:ki

Xc: Dr. Alan Rodman
Dr. D. L. Roberts
Dr. H. E. Stowe
Dr. R. L. Rowland
Dr. C. R. Green
Dr. R. A. Lloyd
Dr. Duo Lynn
Mr. R. E. Shackelford
Dr. R. F. Moates
Dr. C. L. Neumann
Dr. C. E. Rix
Dr. J. P. Dickerson

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RJR

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UPDATE ON THE SMOKING AND HEALTH ISSUE AND SMOKING SATISFACTION

To: Mr. J. F. Hind

From: Murray Senkus

November 17, 1977

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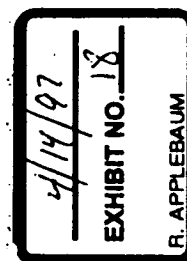


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J. F. Hind

UPDATE ON THE SMOKING AND HEALTH ISSUE AND SMOKING SATISFACTIONScope of The Smoking And Health Issue And Smoking Satisfaction

Publications on the alleged hazards of smoking appeared as early as the 16th century when tobacco was first introduced into Europe by the Spanish conquerors of North and South America. But the most persistent series of attacks on smoking began in the early 1950's when Ernest Wynder and a renowned surgeon of Washington University of St. Louis, Missouri, Dr. Evarts Graham, alleged in a number of articles that smoking is harmful to health on the basis of certain statistical and anecdotal data. 1, 2, 3.

Since the early 1950's other research organizations and institutions have become involved in the question of smoking and health. Some of these organizations and institutions support the original stand of Wynder et al. that smoking is harmful to health. Others, however, maintain that the relationship between smoking and health is an open question.

The number of organizations involved in smoking and health is growing. At the moment one could list the following who have published on this subject: (1) National Cancer Institute; (2) National Heart and Lung Institute; (3) American Cancer Society; (4) American Health Foundation; (5) The Various State Experiment Stations; (6) The University of Kentucky Tobacco and Health Research Program; (7) The United States Department of Agriculture; (8) The Environmental Protection Agency; (9) The Action On Smoking and Health (ASH); (10) The Group Against Smokers' Pollution (GASP); (11) The Federal Trade Commission; (12) Harvard University Smoking and Health Research; (13) Council For Tobacco Research; (14) Association of The Cigarette Industry of West Germany (Verband der Cigarettenindustrie); (15) The British Health Ministry; (16) The Institute of Psychiatry of the Maudsley Hospital of the University of London; (17) Department of Psychiatry at the University of California at Los Angeles; and (18) Columbia University.

There are, of course, other institutions doing research on the smoking and health question. They are either privately funded or funded by some branch of the Government such as the National Cancer Institute.

Regardless of the reports in the press or in the medical journals claiming that the relationship between smoking and health has been proven,

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the tobacco industry in America does not accept these claims. The tobacco industry and in particular the management of R. J. Reynolds Tobacco Company maintain that the relationship is still an open question.

The present report is an update on the smoking and health issue reviewing the status of research in some of the organizations and institutions listed above. The report also includes a review of discussions with a number of scientists who have carried on research in the smoking and health area.

Smoking and Health Program of the National Cancer Institute

The smoking and health program of the National Cancer Institute was instituted in 1968. In establishing the smoking and health program, the Institute recognized that a very substantial part of the population will continue to smoke and in view of this presumption, and in view of the government belief that smoking is hazardous to health, a program was assigned the goal of developing an allegedly safer cigarette.

To date, about 120 experimental cigarettes have been designed and tested by painting their smoke condensates on the skins of mice. Based on results to date, Dr. Gori, the Director of the Program has concluded that the following characteristics of cigarettes provide for less smoking:

1. Use of high porosity cigarette paper.
2. Large proportion of reconstituted tobacco and stems in the blend.
3. Extraction of tobacco with a suitable combination of hexane, water and surface active agents.
4. Use of inert fillers, such as clay and/or dolomite, as tobacco extenders.
5. Use of tobacco varieties from selected cultural and curing methods.
6. Nicotine reduced to an appropriate level.
7. "Tar" reduced to as low level as is conceivably possible.
8. Nitrogen oxides, carbon monoxide, hydrogen cyanide and acrolein reduced to an appropriate level.
9. Use of air-dilution filters.
10. Use of safe flavor additives to insure acceptability, both from health and smoking satisfaction standpoints.

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r. G. Gori, the Director of the Smoking and Health Program of the National Cancer Institute believes that by implementation of the technology set forth above, it is possible now to produce a safe cigarette. Not only does he recommend the above technology, he prescribes a way to smoke safely in a recent article in "Science".⁴ His prescription is:

"Tar" limit per day - 151 mg.
Nicotine limit per day - 10.5 mg.
Cigarette limit per day - 20

person were to limit himself to 20 cigarettes per day he would a range of "tars" and nictines. Here are three possibilities:

"Tar" per cigarette (mg.)	-	7.5	5.0	2.5
Nicotine per cigarette (mg.)	-	.5	.5	.5
"Tar" to nicotine ratio	-	15	10	5

The article suggests that the "tar" to nicotine ratio should be as low as possible to achieve maximum taste and satisfaction.

Further impetus to the development of an allegedly safer cigarette was recently by Dr. Peter Bourne, President Carter's Special Assistant for Health Issues. He addressed the Ad Hoc Committee on Tobacco and Smoking Research of the American Cancer Society on November 10, 1977, and urged the adoption of low "tar" cigarettes by those who choose to smoke. Accordingly, because of Dr. Bourne's stand, Dr. Gori's recommendation will continue to gain additional support. A cigarette with 5.0 mg "tar" and 0.5 mg. nicotine will likely be endorsed as a "safe" cigarette by the National Cancer Institute.

The American Cancer Society

The American Cancer Society has maintained for some time that lung cancer death rate of men who smoked cigarettes regularly was ten times as high as the lung cancer death rate of men who never smoked; and this ratio was considerably higher among men who smoked 40 or more cigarettes a day. Using the same comparison, the Society claimed that coronary heart disease death rates of male cigarette smokers were found to be about 1.5 to 3.0 times as high, depending upon age and amount of smoking, as the coronary heart disease death rate of non-smokers. While still maintaining the above, the Society took notice recently of evidence that allegedly suggested that "the lower the 'tar' and nicotine content of cigarette smoke the less harmful would be the effects",⁵ and decided to put this evidence to an epidemiological test. The test has now been completed and results have been published.⁶

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The authors of the paper point out that cigarettes with reduced "tar" and nicotine have not yet been available for a sufficient time to enable them to fully assess the health effects of these reductions. Nonetheless, the preliminary epidemiological study indicates reduction in risk with reduction in "tar" and nicotine. But more significantly, the authors make a recommendation to reduce "tars" and nicotine by the following final note in the article: "The threat to the future health of those who make this youth decision (to smoke) would be reduced if high 'tar' - high nicotine cigarettes were removed from the market. Manufacturers may be willing to do so voluntarily in the light of the fact that long-term trends have been in this direction."

The report from the American Cancer Society is noteworthy because it indicates a decided softening on the smoking-health issue on the part of an organization which at one time was adamantly opposed to smoking. The Society will continue to collect additional epidemiological data, and may eventually obtain data which will show that a 5 mg. - 0.5 mg. cigarette is an allegedly safe cigarette.

The American Cancer Society held Forums in eight major cities across the United States in the early part of 1977. The witnesses at these Forums advocated among other things:

- 1. Restriction of smoking in public places and places of employment.
- 2. Increase in anti-smoking TV and radio commercials.
- 3. Education of the public at all age levels on the alleged hazards of smoking.
- 4. Legislation at federal, state, and local levels to restrict smoking.
- 5. Elimination of tobacco subsidy.
- 6. Restriction on cigarette advertising.
- 7. Placing cigarettes under FDA regulation.

Since the Society has not issued a report on these proceedings; however, it would seem that its recommendations regarding restriction of smoking have changed recently in view of the recent election of Dr. R. Wayne Rundles as the new President of the Society. In a talk in Durham to the City Chapter and speaking on behalf of the Society, he stated that we cannot abolish smoking and recommended that consumers change to low "tar" cigarettes. In view of Dr. Rundles' election to the Presidency, it can be expected that the American Cancer Society will take a more reasonable view of the smoking and health issue.

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The Institute of Psychiatry of the Maudsley Hospital of the University of London

The Institute of Psychiatry of the Maudsley Hospital of the University of London established a research program to study the psychological aspects of smoking. The project is headed by Dr. M. A. H. Russell, a practicing psychiatrist. The program was established by the University under the alleged assumption that smoking is hazardous to health, and its original aim was to find means to reduce smoking in the United Kingdom.

After appreciable research on this project, Dr. Russell has concluded that the so-called traditional methods of health education, treatment clinics and anti-smoking propaganda in the United Kingdom are ineffective. He contends that smoking-control programs are not realistic. He is convinced that the goal of "no smoking" should be changed to the goal of "safer smoking". In an article entitled "Realistic Goals for Smoking and Health - A Case For Safer Smoking" Russell suggests on psychological grounds how one might achieve the goal of "safer smoking".

In developing his argument in the article for the goal for "safer smoking", he first emphasizes that absorption of an appropriate amount of nicotine into the blood by inhalation of cigarette smoke is the reason for smoking. He argues that in early stages of establishing a smoking habit, the absorption of nicotine plays a decisive role. Once the habit is established, the person becomes dependent on nicotine, and will continue to smoke. Thus he makes it clear that absorption of an appropriate amount of nicotine is crucial to the smoker.

Russell maintains that once the habit is established, no amount of anti-smoking propaganda will persuade the smoker to abstain. However, interestingly enough, the smoker will respond to other influences without exhortation. For example, among English smokers in 1955, less than 2% of all cigarettes smoked were filters while in 1970 it was over 78%. During this period there was no deliberate program to induce people to switch to filters. While educational programs were attempting to abolish smoking altogether, the enormous change to filters occurred more or less spontaneously. And presently, another change is taking place; namely, to "milder" brands; i.e., low-"tar" nicotine cigarettes. The change to the "milder" brands is also taking place without exhortation. It is simply a spontaneous response to simple information.

Russell believes that the safest cigarette is likely to be the one with a low "tar" yield and a low CO yield and a high nicotine yield. With selective and ventilated filters, he believes it is likely that the manufacturers will soon be able to reduce "tar" and CO substantially and still maintain sufficient nicotine.

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In a recent publication, Dr. Russell updates his interpretation of tobacco smoking and nicotine dependence. In this article he reiterates that smoking is uniquely efficient in administering nicotine and the desired effect is achieved in just a few seconds; whereas in other forms of tobacco usage such as cigars, pipes, and chewing tobacco, the time required for nicotine satisfaction is much longer.

Department of Psychiatry - University of California at Los Angeles
Veterans' Administration Hospital, Brentwood, California

The Department of Psychiatry at the University of California has established a small group of medical research scientists to do research on the psychological and pharmacological properties of various biologically active compounds. In recent years this group has done research on the psychological and pharmacological effects of the use of tobacco in various forms. The group is headed by Dr. Harry E. Jarvik who regards himself as a psychopharmacologist. Dr. Jarvik has used animals in these studies but more recently he has been concentrating on the study of human smoking characteristics. As his human subjects he uses patients at the Veterans' Administration Hospital at Brentwood, California, so most of his work on human smoking characteristics is carried out at the Hospital.

Dr. Jarvik, in agreement with Dr. Russell whose work was discussed in the preceding section of this report, believes that nicotine is the reinforcing agent in cigarette smoking and other tobacco uses. For the last five or six years Dr. Jarvik has been doing research to demonstrate unequivocally the reinforcing property of nicotine in smoking. These views are discussed in his recent article entitled "Reactions To Cigarettes As A Function of Nicotine and 'Tar'".

Dr. Jarvik, as does Dr. Russell, believes that smokers attempt to attain and maintain a relatively constant level of nicotine in their bodies and this level in turn produces a certain level of a desired psychological and/or physiological state. In this connection, he speculates that smokers of full flavor cigarettes, that is, non-filter cigarettes, really get more nicotine than they need. A possibility exists that some of the excess nicotine combines in the body fluids with some biological compound and in this combined state does not exert any physiological or pharmacological effect and is simply held in reserve. Then as the uncombined nicotine is cleared from the system, the combined nicotine is released to prolong the nicotine effect, but if a person does not continue to smoke, all of the nicotine is eventually cleared from this metastable reserve and from the body.

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Dr. Jarvik has observed the relative ease with which non-filter smokers have switched to filter cigarettes and presently are switching to low-"tar" mild cigarettes. It appears obvious that smokers are changing their style of smoking and using more frequent puffs, longer puffs, and deeper inhalation, or are nicotine requirements being met with the smaller amounts of nicotine derived from the low-"tar" cigarettes without a significant change in the style of smoking? To resolve this question he is establishing an analytical method to enable him to determine nicotine in the body fluids. These analytical facilities will not be ready for another half-year or so.

Dr. Jarvik feels very strongly that every effort should be made to encourage people who choose to smoke to switch to low "tar" cigarettes with a higher yield of nicotine relative to "tar" and carbon monoxide. He is confident that people who are now smoking higher "tar" cigarettes experience little difficulty in making the switch to the low "tar" cigarettes with adequate nicotine. He did not specify what he considers adequate nicotine but he did say it would be appreciably above 0.1-mg. level.

Columbia University

At least two groups of scientists are engaged in research on smoking at Columbia University, one group in the Department of Social Psychology, and the other in the Department of Psychiatry in the College of Physicians and Surgeons.

Stefan Schachter and his co-workers at the Department of Social Psychology have been attempting to determine why people smoke. They have finally concluded on the basis of their research that smoking is simply a physical addiction to nicotine.⁹ A confirmed smoker lights up a cigarette to satisfy a craving for nicotine - but not - as some people believe - notably Hans Selye of McGill University - to relieve stress. However, he regards an unsatisfied craving for nicotine as a stressful situation so in this case, Schachter says, smoking would alleviate this particular type of stress.

Schachter agrees with other scientists, such as Gori, Russell, and Jarvik who have recommended low-"tar", low-gas, high nicotine cigarettes. He decidedly discourages the smoking of low-"tar", low-nicotine cigarettes because they would not satisfy the craving for nicotine and would aggravate rather than alleviate stress.

Dr. Jerome H. Jaffe, of the Department of Psychiatry of the College of Physicians and Surgeons, like Schachter, believes that smoking is an addiction to nicotine.¹⁰ In his opinion, smoking is started for various reasons; chief reasons being, (1) to satisfy curiosity, (2) to conform to the behavior of peers, and (3) to rebel against social expectations. Initially, there is no compulsion to smoke, but after repeated uses, a person becomes adjusted to the effect of

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nicotine, and so as soon as the effect wears off, lights up another cigarette. The effect of nicotine from one cigarette lasts a short time, so the smoker replenishes the body's supply several times each hour.

Unlike Schachter, Jarvik, Russell, and others, Jaffe does not support the low-"tar" medium nicotine approach to allegedly "safer" smoking. He speculates that people can be taught to smoke and enjoy the low-"tar", low-nicotine cigarettes and these would allegedly be safer. He is now seeking financial support to establish a research project to demonstrate acceptability and safety of low-"tar", low-nicotine cigarettes. If I were to speculate as to his motive, it is two-fold: one, it would afford a confirmed smoker the opportunity to lose the dependency on nicotine, and thus he would be able to quit smoking without any withdrawal problems; and secondly, the young starting smoker would not become addicted to nicotine, and hence would remain a non-smoker as an adult.

State Experiment Stations

Most tobacco growing states maintain experiment stations where research is conducted on the agronomy of tobacco. The chief areas which are investigated are:

- (1) Development of resistance to disease in tobacco plants.
- (2) Improvement of yield of tobacco.
- (3) Variation of certain key chemical components in the tobacco; i.e., nicotine content.

In conducting these experiments the stations rely heavily on the tobacco companies to evaluate the smoking and manufacturing qualities of their experimental tobaccos. The Agricultural Research Department of R. J. Reynolds Tobacco Company has played a significant role in these evaluations.

C. State Experiment Stations at Oxford, North Carolina, and the University of Kentucky Experiment Station at Lexington, Kentucky, have excelled both in quality and quantity of research on tobacco, the former on flue cured, and the latter on burley tobaccos. Many new useful varieties have been developed, and for the most part, the objectives were to overcome disease resistance and to improve yield, while still maintaining the smoking qualities desired by consumers.

Until recent years, the consumers have preferred the so-called full-flavor cigarettes, delivering at least 15 mg. "tar" and about 1.0 mg. more nicotine. Owing to lack of rainfall and excessive fertilization, the nicotine contents frequently ran high, so the experiment stations had put emphasis on reduction of nicotine tobaccos as they

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The United States Department of Agriculture

at the Beltsville Agricultural Research Center at Beltsville, Maryland, is a project underway under an agreement with the National Cancer Institute to develop tobacco that will be allegedly biologically less active when used in cigarettes.

Experimental tobaccos are being grown which vary in genetic and cultural practices. These are being cured and processed in various ways and samples produced by these experimental processes are evaluated biologically.

One rather unusual process which is being studied is a radical departure from the conventional flue curing process. Upon priming, the leaves of flue cured tobacco are macerated and the slurry is then allowed to ferment at 130 to 140° Fahrenheit. When fermentation is complete, the mash is then converted to a sheet, which is then cut into strips and converted into cigarettes. Since the smoking quality of these cigarettes is highly unsatisfactory, it is unlikely that the product will be used commercially. Nonetheless it is planned to evaluate the biological activity of the smoke of the material with the hope that it will be less biologically active in animal tests.

A feature of this process which has received considerable publicity is the isolation of presumably edible protein from one of the steps. Thus the inventor speculates that the process will provide both an allegedly safer smoking material and an edible protein for human consumption.

Smoking and Health Research Supported By The Industry

Since the mid-1950's, the Tobacco Industry has supported smoking health research at various universities and some research institutions through the Agency of the Council for Tobacco Research (CTR) and the American Medical Association (AMA). Smoking and Health research is also being supported by agreements directly with Harvard University, Washington University at St. Louis, Missouri, and the University of California at Los Angeles. About \$75,000,000 has been expended at CTR and AMA and the other studies to date.

The research is aimed primarily at gaining a better understanding of the biological aspects of smoking and is not applicable to the design or modification of commercial tobacco products.

The University of Kentucky Smoking Health Research

In 1960 the Kentucky Legislature passed a law specifying that the proceeds from a one-half cent per pack tax on cigarettes would be used for Tobacco and Health Research at the University of Kentucky Tobacco and Health Research Institute.

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With the considerable funds which potentially this tax provided, a rather ambitious program was planned in the areas of (1) Tobacco production, (2) Manufacture of Tobacco Products, (3) The Chemistry and Physics of Tobacco Products and Smoke, (4) The Response of Non-human Biological Systems To Tobacco Products, and (5) Human Response to Tobacco Products.

It has taken considerable time to provide facilities and set up organization. Some projects in the above areas have gotten underway. However, nothing has emerged as yet which is likely to have any effect on tobacco products in the foreseeable future.

British Health Ministry

The tobacco industry in Great Britain at one time maintained a research establishment, the Tobacco Research Council, at Harrogate, England, to do work on smoking and health. This joint industry effort was discontinued several years ago. The research has had no direct effect on the design or modification of tobacco products.

The British Health Ministry and the Royal College of Physicians has been exhorting the public to reduce smoking and also to abstain altogether. These efforts have had relatively little effect on per capita cigarette consumption.

The public in Great Britain has however switched from non-filters to filters. Filters represented only 2% of the total market in 1955. Without any exhortation on the part of the Government, filter consumption rose to over 78% of the total cigarette market by 1970. At present, the people are switching to low-"tar", low-nicotine

The British Health Ministry however is playing a key role in deciding on the use of tobacco substitutes, particularly the New Smoking Material (NSM), and Cyrel, the Celanese product. It had appointed the Hunter Committee to conduct tests to determine whether these materials are acceptable for public use.

The Hunter company issued its report in 1977 and authorized the use of NSM and Cyrel in cigarette blends. These new brands containing synthetic tobaccos have not been successful to date. It is now generally believed that the smoking public will not accept tobacco substitutes.

Association of the Cigarette Industry of West Germany

The cigarette industry of West Germany at one time established a smoking and health research institute which conducted biological studies aimed at modification of smoking products. This joint research effort was discontinued recently. The biological studies which have been terminated have not had any impact on products or processes.

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After the closing of the biological research institute, the cigarette industry of West Germany has joined forces to support smoking-health research along the line of the Council for Tobacco Research in the United States.

But seven years ago, the German cigarette industry promoted normal-"tar", low nicotine cigarettes, but these were not successful in the marketplace. There is an indication that the manufacturers of that country will follow the U. S. trend; namely, the promotion of medium-"tar", medium-nicotine or perhaps low-"tar", medium-nicotine cigarettes.

Federal Trade Commission

In its most recent report, the 20th, was issued on August 15, 1977, it listed 166 brands, an increase of 107 brands from November 1977 to October 1977.

Following on the recommendations of certain scientific and medical organizations which alleged that smokers should be encouraged to reduce "tar" and nicotine intake, the U. S. Government through the agency of the Federal Trade Commission arranged in 1967 for the periodic determination and publication of "tar" and nicotine values for all cigarette brands. The first report on 59 brands was issued on November 22, 1967. Since that time, reports have been issued approximately at 6-month intervals. The most recent report, the 20th, was issued on December 10, 1976, and it listed 169 brands, an increase of 110 brands from November 1967 to December 1976.

The 21st report is expected to issue in June 1978 and will likely list "tar" and nicotine values for 167 brands which were picked during the period June 1, 1977 through July 15, 1977.

It has been speculated from time to time that the Federal Trade Commission laboratory will begin the determination and publication of the amounts of certain gas phase components of cigarette smoke, such as acrolein, hydrogen cyanide, nitrogen oxides and carbon monoxide, along with the nicotine and "tar" values.

The most recent word is that concrete steps are being taken for the determination and publication of the carbon monoxide values for all cigarette brands, along with the "tar" and nicotine values. The director of the Federal Trade Commission laboratory has already placed an order for the analytical instrument to determine carbon monoxide.

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He expects it to be installed in December, 1977, so that publication of carbon monoxide values could begin early in June, 1978; however, since considerable time may be necessary to make the new machine operational, publication of carbon monoxide values may not begin until late 1978.

American Health Foundation

American Health Foundation is a tax-exempt organization incorporated in the State of New York. It is engaged in research in preventive medicine. It was founded by Dr. Ernest C. Wynder who along with the late Dr. Graham began the present smoking and health controversy in the early 1950's. Among the present contracts of the Foundation is one on smoking and health which is supported by the National Cancer Institute. It is an epidemiological study of the effects of human smoking of cigarettes of varying "tar" and nicotine contents.

In his early interpretation of the effects of smoking, Dr. Wynder assumed that tobacco smoke contains certain biologically active constituents which arise during the smoking process. He then reasoned that the reduction of the intake of these materials would reduce the alleged health hazard, and based on this assumption he described ways of reducing the exposure. One way was for the smoker to change his smoking style, by refraining from inhalation or taking fewer puffs on a cigarette. Other recommendations were concerned with modification of cigarettes. One was to use additives on tobacco to reduce the formation of allegedly harmful materials. Another recommendation was to extract tobacco with certain liquids to remove precursors of these same materials. The third recommendation was to incorporate filters in cigarettes to reduce the amount of smoke to be taken in by the smoker.

After some twenty-five years of laboratory experiments and epidemiological studies, Dr. Wynder has abandoned the idea of using additives or excipients as a means of modifying cigarettes. In his most recent talks and publications he recommends the reduction of "tar" intake in order to reduce the allegedly harmful effects of cigarette smoke. In essence he agrees with Dr. Gori of the National Cancer Institute whose views on allegedly safe smoking are set forth on pages 2 and 3 of this report.

Dr. Wynder has announced that he will co-author an article in the Scientific American which will likely be published in the early spring of 1978. It is our understanding that in this article he will recommend strongly the reduction of "tar" in cigarettes to 8 mg. per cigarette and nicotine to 0.6 mg. per cigarette.

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Short Summary and Recommendations

A. Recommended "tar", nicotine, and carbon monoxide values.

Applications issuing from the National Cancer Institute, the Department of Psychiatry of the University of London, the Department of Psychiatry of the University of California at Los Angeles, and the University of Columbia allege that for safer smoking, consumers should use brands with "tar", low carbon monoxide, and medium nicotine. Thus it is anticipated that cigarettes with 5 mg. "tar", 0.5 to 0.8 mg. nicotine and 1 mg. carbon monoxide will gain wider consumer acceptance.

The cigarettes will obtain a "qualified" endorsement as "safer" coming from an increasing number of health authorities and their sales will continue to grow as people begin to feel less anxiety about smoking them.

Reynolds Tobacco Company has the technology, the manufacturing and the marketing capabilities to introduce and successfully market brands in this category.

Development and introduction of these brands is recommended.

B. Raw materials

Tobaccos with higher nicotine content will be needed than currently available to meet the requirements for the forthcoming low-"tar", medium-nicotine brands. It is probable that seed for these tobaccos have already been developed. Availability of seed for farmers should be expedited to enable agronomic production of the higher nicotine tobaccos.

Murray Senkus

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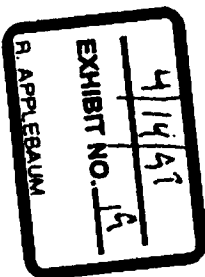
RESEARCH PLANNING MEMORANDUM

ON

**THE NATURE OF THE TOBACCO BUSINESS AND THE CRUCIAL
ROLE OF NICOTINE THEREIN**

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contradictory effects attributed to it. Many of these same effects may be achieved with other physiologically active materials such as caffeine, alcohol, tranquilizers, sedatives, euphorics, and the like. Therefore, in addition to competing with products of the tobacco industry, our products may, in a sense, compete with a variety of other products with certain types of drug action. All of these products, tobacco and other, appear to have certain common attributes in that they are used largely to relieve, in one way or another, the fatigues and stresses which arise in the course of existence in a complex society.

Happily for the tobacco industry, nicotine is both habituating and unique in its variety of physiological actions, hence no other active material or combination of materials provides equivalent "satisfaction". Whether nicotine will, over the long term, maintain its unique position is subject to some reasonable doubt. With increased sophistication of knowledge in the biological and pharmaceutical areas, a superior or at least equivalent product or product mixture may emerge. For this reason, it would be a mistake to assume that the tobacco industry, as we now know it, is immortal or that direct competition from organizations outside of the tobacco industry will ever occur. It is safe to assume, however, that nicotine will retain its unique position throughout the present ten year planning period, and probably for a much longer span of time.

If nicotine is the sine qua non of tobacco products and tobacco products are recognized as being attractive dosage forms of nicotine, then it is logical to design our products -- and where possible, our advertising -- around nicotine delivery rather than "tar" delivery or flavor. To do this we need to

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develop new data on such things as the physiological effects of nicotine, the rate of absorption and elimination of nicotine delivered in different doses at different frequencies and by different routes, and ways of enhancing or diminishing nicotine effects and "satisfactions". In the absence of such data, we may survey the market and conclude that current cigarette products delivering about 1.3 mg. of nicotine appear to "satisfy" the typical smoker. This, somewhat crudely, establishes a target dosage level for design of new products. An accompanying Research Planning Proposal describes that approach in some detail. However, if we knew more about nicotine absorption, action, elimination, enhancement and the like, it should, in theory, be possible to more precisely specify, and deliver, the optimum amounts of nicotine activity in sophisticated products which would be more satisfying and desirable to the user. This area merits consideration and activity.

Before proceeding too far in the direction of design of dosage forms for nicotine, it may be well to consider another aspect of our business; that is, the factors which induce a pre-smoker or non-smoker to become a habituated smoker. Paradoxically, the things which keep a confirmed smoker habituated and "satisfied", i.e., nicotine and secondary physical and manipulative gratifications, are unknown and/or largely unexplained to the non-smoker. He does not start smoking to obtain undefined physiological gratifications or reliefs, and certainly he does not start to smoke to satisfy a non-existent craving for nicotine. Rather, he appears to start to smoke for purely psychological reasons -- to emulate a valued image, to conform, to experiment, to defy, to be daring, to have something to do with his hands, and the like. Only after experiencing smoking for some period of time do the physiological "satisfactions" and habituation become apparent and needed. Indeed, the first

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smoking experiences are often unpleasant until a tolerance for nicotine has been developed. This leaves us, then, in the position of attempting to design and promote the same product to two different types of market with two different sets of motivations, needs and expectations. The same situation is encountered in some industries, but the problem is usually not as severe.

If what we have said about the habituated smoker is true, then products designed for him should emphasize nicotine, nicotine delivery efficiency, nicotine satisfaction, and the like. What we should really make and sell would be the proper dosage form of nicotine with as many other built-in attractions and gratifications as possible — that is, an efficient nicotine delivery system with satisfactory flavor, mildness, convenience, cost, etc. On the other hand, if we are to attract the non-smoker or pre-smoker, there is nothing in this type of product that he would currently understand or desire. We have deliberately played down the role of nicotine, hence the non-smoker has little or no knowledge of what satisfactions it may offer him and no desire to try it. Instead, we somehow must convince him with wholly irrational reasons that he should try smoking, in the hope that he will for himself then discover the real "satisfactions" obtainable. And, of course, the present advertising climate, our opportunities to talk to the pre-smoker are increasingly limited, and therefore increasingly ineffective. Would it not be better, in the long run, to identify in our own minds and in the minds of our customers what we are really selling, i.e., nicotine satisfaction? This would enable us to speak directly of the virtues of our product to the confirmed smoker, and would educate the pre-smoker, perhaps indirectly but effectively, in what we have to offer and what it would be expected to do for him.

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But again, the picture is not quite all that clear. Critics of tobacco products increasingly allege that smoking is dangerous to the health of the smoker. Part of this alleged danger is claimed to arise from ingestion of nicotine and part is claimed to arise from smoke components or smoke "tar". If, as proposed above, nicotine is the sine qua non of smoking, and if we meekly accept the allegations of our critics and move toward reduction or elimination of nicotine from our products, then we shall eventually liquidate our business. If we intend to remain in business and our business is the manufacture and sale of dosage forms of nicotine, then at some point we must make a stand. We should know more, rather than less, than our critics about the physiological effects of nicotine, and we should in all ways scientifically validate and speak to the beneficial effects and "satisfaction" derived from use of nicotine. Essentially all commercial drugs give rise to some undesirable side effects, but we continue to use them with great benefit to humanity because of their overriding beneficial effects. Might we not take a leaf from that book in our approach to nicotine? Unless we do, our long-term prospects become unattractive.

Our critics have lumped "tar" and nicotine together in their allegations about health hazards, perhaps because "tar" and nicotine are generated together in varying proportions when tobacco is smoked. An accompanying Research Planning Memorandum suggests an approach to reducing the amount of "tar" in cigarette smoke per unit of nicotine. That is probably the most realistic approach in today's market for conventional cigarette products. However, another more futuristic approach is possible which goes more directly to the fundamentals of the alleged problem.

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If our business is fundamentally that of supplying nicotine in useful dosage form, why is it really necessary that allegedly harmful "tar" accompany that nicotine? There should be some simpler, "cleaner", more efficient and direct way to provide the desired nicotine dosage than the present system involving combustion of tobacco or even chewing of tobacco. A conventional 1000 mg. tobacco rod containing about 20 mg. of nicotine is smoked to produce only about 1.3 mg of smoke nicotine, accompanied by about 20 mg. of "tar" and 20 mg. of gas phase matter; and a substantial part of the 1.3 mg of smoke nicotine is lost to the smoker via exhaled smoke -- surely an inefficient nicotine delivery system. It should be possible to obtain pure nicotine by synthesis or from high-nicotine tobacco. It should then be possible, using modifications of techniques developed by the pharmaceutical and other industries, to deliver that nicotine to the user in an efficient, effective, attractive dosage form, accompanied by no "tar", gas phase, or other allegedly harmful substances. The dosage form could incorporate various flavorants, enhancers, and like desirable additives, and would be designed to deliver the minimum effective amount of nicotine at the desired release-rate to supply the "satisfaction" desired by the user. Such a product would maximize the benefits derived from nicotine, minimize allegedly undesirable over-dosage side effects from nicotine, and eliminate exposure to other materials alleged to be harmful to the user. For the time being, we should be working toward development of such products -- if we do not, inevitably someone else will, and there are strong indications that others are already moving in this direction.

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In the present real situation, where nothing has been done to counteract the adverse allegations about nicotine and where conventional products delivering adequate amounts of nicotine dominate the marketplace, no abrupt change in our posture or strategy would be appropriate or reasonable. The approaches advocated above are aimed at stopping and eventually reversing a trend that may in the long term put us out of business, and are intended to lay a framework of philosophy around which research efforts may now begin. Hopefully, some day we will rejoice rather than despair when a new crop of tobacco shows an unusually high content of nicotine, our primary product. Hopefully, with time we will be able to develop sophisticated and improved minimum dosage forms for nicotine which will be more satisfying to the user and free of alleged health hazards. And hopefully, by that time, we will have been able to establish and use information showing that use of nicotine fills real, demonstrable human needs, the beneficial effects overriding the allegedly harmful side effects.

INDICATED RESEARCH DEPARTMENT ACTIVITIES AND APPROACHES:

If the above is a valid line of reasoning, then our long-term future of action should be as follow:

1. Recognize the key role of nicotine in consumer satisfaction, and and promote our products with this in mind.
2. More precisely define the minimum amount of nicotine required for "satisfaction" in terms of dose levels, dose frequency, dosage form, and the like. This would involve biological and other experiments.
3. Sponsor in-depth studies of the physiological, psychological and other effects of nicotine, aimed at demonstrating the beneficial effects of nicotine and at disproving allegations that nicotine produces major adverse effects.

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4. Study, design and evaluate new or improved systems for delivery of nicotine which will provide the minimum satisfying amount of nicotine in attractive form, free of allegedly harmful combustion products.
5. Study means for enhancing nicotine satisfaction via synergists, alteration of pH, or other means, to minimize dose level and maximize desired effects.
6. Monitor developments in materials and products which may compete with nicotine products or which might be combined with nicotine products to provide added advantages or satisfactions.
7. Monitor work by others which might be aimed at improved nicotine delivery systems of the type proposed here.
8. Search for and evaluate other physiologically active components of tobacco or its smoke which may provide desired effects to the smoker.

Claude E. League, Jr.
 Claude E. League, Jr.
 April 14, 1972

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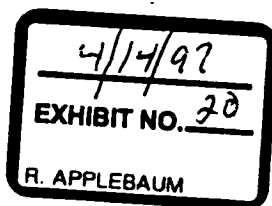
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PLANNING ASSUMPTIONS AND FORECAST FOR THE PERIOD 1977-1986⁺

FOR

R. J. REYNOLDS TOBACCO COMPANY

- I. THE GENERAL BUSINESS CLIMATE
- II. THE TOBACCO INDUSTRY AND R. J. REYNOLDS TOBACCO COMPANY
- III. THE RESEARCH DEPARTMENT
 - A. GENERAL
 - B. SMOKING AND HEALTH
 - C. REGULATION, TAXATION, ETC.
 - D. RAW MATERIALS AND PROCESSES
 - E. PRODUCTS
 - F. MISCELLANEOUS



Research Department
March 15, 1976

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I. THE GENERAL BUSINESS CLIMATE

1. No sudden change will occur in the "system" or business environment in which we operate, i.e., there will be no catastrophic pestilence, disease, world war, revolution, major depression, natural disaster, or the like. There is a possibility of renewed warfare in the Mid-East probably again accompanied by a petroleum crisis.
2. As the present "under 35" age group becomes the dominant power group in our society, the new personal and political values of that group will exert a more predictable influence for change upon most aspects of government, society, business, morality and foreign policy. The changes which occur are not expected to be favorable to business. However, this large consumer group will have needs to be satisfied. In terms of tobacco products. This offers us a large market if we are sufficiently astute to identify those needs and design and sell products to meet them.
3. World leaders of morality, such as the Pope, will exert great influence to modify the personal mores, and consequently the civil and political values, of the present "under thirty" age group. There may be a strong swing toward wholesomeness, integrity and decency which will affect the consumer outlook and product expectations of this group. Price, quality and durability will become more important than fad, flamboyant fashion or sex appeal.
4. The "consumerism" movement will remain strong, and the ability of consumers to objectively judge the quality and utility of products may increase. Product labeling will become more definitive in terms of composition, date, hazards, and the like.
5. Present socio-legal-governmental trends will continue. Concern for "social justice", environment, energy, population control, and product safety will remain high. Governmental regulation of almost all aspects of our society will increase.
6. The energy shortage and to a lesser extent other material shortages over the next decade will cause a change in world economy and politics, a change in national priorities and life style, and increased cost and difficulty in doing business. Concern for environment will remain high among certain groups; and although energy needs will finally outweigh environment considerations, the environmental groups will continue to fight and delay. These influences will continue beyond the projection period and will intensify as energy needs and environment consideration exert a greater effect on the average person.
7. The U. S. standard of living will not increase at the rate of the last decade. The amount of discretionary income will decrease. The main squeeze will be on the middle economic class.

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1. THE GENERAL BUSINESS CLIMATE (cont'd)

8. The health consciousness and technical understanding of the population as applied to products, will increase. — ?
9. Price-wage-profit controls will remain a possibility for at least several more years.
10. Coping with the business cycle will remain difficult. The profit squeeze will remain a major problem unless periodic "pass-through" price increases are competitively feasible and allowable.
11. Due in large part to political tampering with an economy already under real stress, it was long thought that the economy would cycle between high unemployment and high inflation at about 2 to 3-year intervals. However, it is apparent from recent experience that this idea should be abandoned. For several years unemployment and inflation have been cycling together. As a 10-year average, inflation will probably run at about 8% and unemployment at about 8%; i.e., politicians will continue, in election years, to place more emphasis upon full employment than upon price stability. Also for complex reasons, the government is committed to a continued policy of inflation.
12. A key factor in the control of the economy's vigor is the decreasing birth rate. Even at current levels, every facet of the juvenile market may expect to be depressed. And only a few years beyond the production period looms a markedly reduced generation of young adults who will need consumer goods. This may provide a built-in cooling of the economy, leading toward less inflation and specialized areas of unemployment.
13. More and more evidence of financial mishandling by cities, states, and national governments will leak through to the public in the immediate future. The root causes, such as overextending in welfare programs, abuse of expenditures in such programs, corruption, waste, unwise and expensive experimentation with educational programs, and unnecessary services will become more evident to the public and will elicit strong response and possibly backlash. Considerable instability in municipal, state and federal spending policies and programs will result, with attendant uncertainties in taxation outlook.

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II. THE TOBACCO INDUSTRY AND R. J.
REYNOLDS TOBACCO COMPANY

III. THE RESEARCH DEPARTMENT

A. General

2. RJR-T has a great opportunity to capitalize on the growing foreign market, particularly the market in "emerging nations". Increasing trade barriers and international monetary difficulties, increased regulation and taxation of tobacco products in foreign countries, and increased requirements that much of the tobacco used be "home grown" will add to the difficulty in penetrating these markets.
3. Over the long run the influence and political power of the industry will decrease.
4. Total cigarette consumption in the U.S.A. as well as per capita cigarette consumption will be affected principally by the following demand factors (listed in order of estimated decreasing importance):
 - a. Total U.S. population (18 and over)
 - b. Age distribution within this population.
 - c. Taxation and other cigarette price factors
 - d. The impact of the health controversy.
 - e. The per capita disposable income

For the projection period, per capita consumption will stay level, at best, and may tend to decrease as the percentage of new smokers decreases. It can be assumed that the other factors will have their "logical" impacts. Thus, the long-range unit sales will increase no more than 2% per year. For RJR-T, the unit sales increase will exceed that of the industry at least in the first few years of the projection period.
5. The public concern over energy, inflation, political integrity, unemployment, etc. will create a period of national psychological stress, during which smoking-health concerns may be overshadowed.
6. The declining birthrate, if continued, indicates decreased cigarette sales in 15 to 20 years, due to the reduced consumption by the then large over-50 age group.

2. Research Department will be interested in RJR-T on request (probably through RJR-T).

*Opportunity to upgrade
techniques with in-house techniques*

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II. THE TOBACCO INDUSTRY AND R. J. REYNOLDS TOBACCO COMPANY

B. Smoking and Health

1. The scientific controversy over the alleged effects of smoking on the health of the smoker will stabilize or abate, provided Industry, Government and other groups begin to reach a truly constructive, collaborate consensus and joint effort; otherwise it may intensify. A hard-core anti-tobacco group will always remain and will be joined by anti-big business groups in attacks on the tobacco industry.

2. The negative effect of the smoking-health controversy on consumer behavior is approaching a maximum, i.e., no new adverse data would be expected to materially change the attitude of the public toward smoking and health.

3. The anti-tobacco lobby, in addition to harping on the alleged association of cigarette smoke with cancer and other diseases, will aim a major long-range thrust at smoking in attempt to stigmatize it as a socially objectionable and lower class habit. One of the major tools in this endeavor will be the campaign against the effects of environmental smoke which is labeled "passive smoking". "Passive smoking" is defined as the exposure to tobacco smoke by nonsmokers. Three related but distinct areas need be considered:

a. Legislative activities of anti-tobacco forces aimed at prohibiting or restricting smoking in public places such as restaurants, semi-public places such as the working place in general, including offices, factories, etc. A concerted effort to counteract these activities is being made by the Tobacco Institute; no RJR initiative is needed.

b. The long-range, more important, second area is the unequivocal declaration to stop smoking an objectionable habit. Very little is being done to contest this industry-wide, and an RJR-led effort could be highly important.

III. THE RESEARCH DEPARTMENT

1. Smoking-health research done on a collaborative basis by Company, and private or academic groups will require the Research Department to provide inputs such as consultation, analyses, and possibly various laboratory studies.

Research related to the smoking controversy will continue to receive major short- and long-term emphasis.

2. Awareness will be maintained by Department.

3. Techniques to determine comparative quality of sidestream smoke inhaled by nonsmoker is exposed will be developed.

*Low tar cigarettes
the ratio of tar to nicotine
released to the non-smoker
central side stream
may be a future goal*

II. THE TOBACCO INDUSTRY AND R. J. REYNOLDS TOBACCO COMPANY

III. THE RESEARCH DEPARTMENT

E. Products

1. WINSTON and SALEM market shares will peak and then decline during the projection period. Marlboro will displace WINSTON as the leading domestic cigarette in 1976. Our objective is to maintain RJR-T as the leading company in our industry.

Extremely important are our related objectives to have a leading product in each category and to discover and produce leading products in new categories.

2. The present large number of people in the 18 to 35 year age group represents the greatest opportunity for long-term cigarette sales growth. Young people will continue to become smokers at or above the present rates during the projection period. ~~the~~ brands which these beginning smokers accept and use will become the dominant brands in future years. Evidence now available to indicate that the 14 to 18 year old group is an increasing segment of the smoking population. RJR must soon establish a successful new brand in this market if our position in the industry is to be maintained over the long term.

3. The total market for low "tar" and nicotine brands will continue to grow. The 100-mm (and 100-mm+) regular and menthol categories will also continue to grow. Combinations of these categories (100-mm low "tar" cigarette in the 4- to 6-mg range, regular and menthol) offer new opportunities. The market for very low "tar" cigarettes (2 mg or less) will remain limited for at least 5 years. The low-"tar" cigarette opportunities in the 2- to 10-mg range will be exploited in the next few years and may become an important market segment by 1981.

1. Work to improve smoke quality innovations directed toward development of new brands will continue to receive major short- and long-term emphasis.

2. Work to improve smoke quality innovations directed toward development of new brands will continue to receive major short- and long-term emphasis.

3. Work to improve smoke quality innovations directed toward development of new brands will continue to receive major short- and long-term emphasis.

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15. Adult Smokers Under 25 Will Show a Major Shift in Brand Preference
16. Menthol and Extra Long Cigarettes Will Continue to Grow, but this Growth Will be Concentrated
17. RJR and Philip Morris only Cigarette Companies Showing Share Growth
18. Lifestyles and Values Will Continue to Change With the Continued Breakdown of Traditionalism and Growth Focused on Self-realization
19. Advertising Space is Growing Increasingly Limited vs. Demand Thereby Reducing Impact Per Exposure
20. Media Costs Will Increase More Rapidly Than the General Inflation Rate
21. Exoneration
22. Cure for Diseases Allegedly Related to Smoking
23. RJR Risks Government Intervention Due to Market Concentration
24. A Non-Cigarette Cigarette
25. Technical Breakthrough to Aid Person to "quit" More Easily
26. Price Elasticity of Cigarettes
27. Competition From Foreign Marketers
28. Enforcement Practices

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Productive
Protective Order

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CONSUMER HEALTH CONCERNS1. Trend/Issue/Event

Increased health concerns about cigarette smoking from smokers and non-smokers.

2. What Will Happen?

Concerns will continue to increase as government, media and the industry itself concentrate on the health controversy.

3. What Will Be Its Impact/Implication?

Increased demand for cigarettes that are perceived to alleviate the health concerns (e. g., lower 'tar', reduced gas) with an attendant decline in demand for cigarettes which do not do so (e. g., higher 'tar', full or middle flavor) - opportunity.

Continued decline in smoking incidence, and per capita consumption as a result of fewer new smokers and/or more quitters - threat.

4. When Will It Happen?

Trend will continue at an accelerating pace into the 1980's.

5. Sources:

MRO consumer studies; current and forecasted cigarette category performance; government and media press releases; trends in industry new brand direction, advertising, promotion; anti-smoking propaganda distributed via schools, health organizations and public interest groups... confirm upward trend in health concern.

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SOCIAL ACCEPTABILITY OF CIGARETTES1. Trend/Issue/Event

Cigarette smoking and the cigarette smoker are being targeted by the government, media and crusading non-smokers.

2. What Will Happen?

The social acceptability of cigarette smoking will continue to decline in the near term - threat.

3. What Will Be Its Impact/Implication?

Total consumption will decline due to lower incidence, lower per capita consumption among smokers, fewer new smokers, and/or more quitters.

4. When Will It Happen?

Trend emerged in early '70's and will accelerate in late '70's.

5. Sources:

Government imposed restrictions (federal, state, local) on public smoking; World Health Conference report stating their primary aim is to denigrate cigarette smoking and the smoker; Tobacco Institute releases; government and media press releases; anti-smoking propaganda distributed via schools and public interest groups... confirm continued trend toward restrictive legislation and denigration of cigarette smokers.

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1. Trend/Issue/Event

Increasing threat of greater governmental imposed restrictions on cigarette advertising, promotion, and labeling.

2. What Will Happen?

Increased restrictions may occur in the following areas:

- A. Labeling... 'tar' and nicotine legend required on packaging; new gas labeling requirements.
- B. Copy... increased size of health warning and T & N legend; addition of gas level identification; restrictions on "imagery" advertising (e. g., further restrictions on/elimination of people in ads, restriction on lifestyle depiction, etc.).
- C. Media... selective elimination of various media forms (e. g., outdoor); increased restrictions on media that deliver sizeable young adult audience.

3. What Will Be Its Impact/Implication?

Ability to effectively deliver advertising and promotion programs to consumers will be limited. Inter-company competition within the industry will be reduced - threat.

4. When Will It Happen?

Unknown. Likelihood is dependent primarily on the philosophy of key government agencies (e. g., FTC) and the Congress.

5. Sources:

Past and current government restrictions/regulations; current FTC consideration of additional restrictions (e. g., FTC Report to Congress, current warning size issue in outdoor); proposals from anti-smoking public interest groups (e. g., ASH); anti-tobacco elected officials (e. g., Senator Moss); trend in restrictive legislation in foreign countries (e. g., Great Britain); media editorial... indicate that cigarette marketing practices are still the subject of intense scrutiny.

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GRADUATED CIGARETTE TAX (Based on T & N Levels)1. Trend/Issue/Event

Threat of a new Federal excise tax based on 'tar' and nicotine levels.

2. What Will Happen?

The Federal government will drop the current 8¢ per pack excise tax in favor of a graduated excise tax based on 'tar' and nicotine levels. Higher T & N brands would be taxed at a higher rate.

3. What Will Be Its Impact/Implication?

Excise taxes will be passed along to consumers, resulting in a graduated price structure at retail: higher T & N cigarettes will cost more than lower T & N cigarettes - threat.

Consumption of lower 'tar' and nicotine cigarettes will increase - opportunity.

4. When Will It Happen?

Unknown. Hart-Kennedy bill proposed in 1976 Congress as amendment to Tax Reform Act of 1976. Amendment died in Senate Finance Committee.

5. Sources:

Hart-Kennedy bill proposed 1976; N. Y. City experience with graduated tax based on T & N.

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INDUSTRY TREND TOWARD LOW-'TAR' CIGARETTES1. Issue

Cigarettes having 14 mgs. 'tar' and less become the largest volume category in the industry.

2. What Will Happen?

- Concern about smoking increases among all smokers.
- Increased adverse publicity about smoking and health-gas controversy becomes a new facet.
- Significant increases in consumer interest in/knowledge of 'tar' levels.
- Cigarette makers continue onslaught of low 'tar' and low 'tar'-low gas advertising thus creating increased consumer awareness.
- All new brands will be low 'tar' (14 mgs. and less).

3. Impact/Implications

- Hi-fi brands will account for 40+% of total industry sales by 1985.
- Hi-fi will be the only growth category in the industry.
- Market restructures itself as hi-fi growth expected across all categories--king size/100's, menthol/non-menthol, "full flavor" perception hi-fi brands, "health" perception super-low 'tar' brands.
- Great opportunity for new brands--(of 40+% SOM of hi-fi's by 1985 nearly two-thirds will be from brands not on the market in 1975).
- Lowered 'tar' levels on established brands is essential to continue to satisfy consumer needs and maintain brand vitality.
- Shift to lower 'tar' levels creates decline in smoking satisfaction which could retard unit growth of industry.
- Maximization of taste/satisfaction in low 'tar' cigarettes is greatest R&D challenge.

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4. When Will It Happen?

- It's happening now!
- Trend can be traced back over 25 years.
- Tremendous acceleration since 1970.
- Hi-fi brands have grown 50% in share from 10% in 1975 to 15% in 1976.
- Greatest growth projected between 1975-1980.

5. Source of Analyses/Forecast/Rationale

- "Anti" and government publicity increases consumer concern about smoking.
- MRD analyses reflect slower industry growth, continued decline in incidence, share/volume increases of hi-fi brands.

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1. Issue

Widespread consumer publicity alleging harmful effects of carbon monoxide and other gases in cigarettes.

2. What Will Happen?

- FTC publishes CO levels (and possibly other gases) along with 'tar' and nicotine report - with resultant adverse "scare" publicity probably initiated by READER'S DIGEST.
- Consumer health concern and serious interest in cigarette smoke components increases at even faster rate.
- B&W aggressively promotes Fact - pushed as low 'tar' - low gas cigarette.

3. Impact/Implications

- Government endorsement and widespread publicity causes serious consumer concern leading to reduced unit volume growth and/or changing brand preferences.
- Cigarette manufacturers add gas control via air dilution to R&D technological challenge of maximizing smoking satisfaction in low 'tar' cigarettes.
- New brands emerge which focus on CO and/or overall gas reduction as primary consumer benefit. Most of these brands will be in super low category (i.e., less than 6 mgs. 'tar').

4. When Will It Happen?

- FTC measurements expected to be published by Fall 1978 report at the latest.
- Consumer publicity will escalate immediately with significant coverage in follow-up READER'S DIGEST report receiving widespread pick-up by local/national media.
- Even with publicity, consumer brand preference will not be affected until cigarette makers feature low-gas advertising related to new brands which will "educate" consumers and provide reason why for brand switching.

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Major volume impact, including brand preference changes, could begin with government publicity/FTC publication of CO in the Fall of 1978--although, barring spectacular publicity like the 1964 READER'S DIGEST report/official government position--naming "favored" brands, this impact should be minimal through 1979.

5. Sources of Analyses/Forecast/Rationale

- MRD tracking indicates continued increase in concern about smoking--CO (gases) adds another facet to the controversy.
- READER'S DIGEST article of October 1976 boosted visibility of issue coupled with widespread media pick-up--additional adverse publicity expected to follow.
- FTC publication of CO and possibly other gases along with 'tar' and nicotine report beginning Fall 1978, per RJR R&D management.

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GOVERNMENT BAN ON HIGH-'TAR' CIGARETTES1. Issue

Possible government ban on cigarettes having over a certain level of 'tar'.

2. What Will Happen?

Anti-smoking publicity over alleged harmful effects of smoking--especially related to high 'tar' cigarettes--leads to government prohibition on sale of any cigarette having more than 20 mgs. 'tar' per FTC.

3. Impact/Implications

- Long-term could lead to total prohibition on all cigarettes.
- In shorter-term, overall "scare" of such a ban could reduce unit volume growth of industry.
- Cigarette makers will immediately reduce 'tar' of affected brands--includes RJR's CAMEL REGULAR and MORE cigarettes.
- Adverse publicity further increases concern about health/smoking and accelerates trend to low 'tar' brands.
- 'Tar' level of 17+ given widespread publicity--print and broadcast--via Mr. Hammond's announcement of "definitive evidence" indicates its safer to smoke low 'tar' brands.
- RJR should lead tobacco industry in vigorously fighting such restrictions including continued aggressiveness in opposing Hart/Kennedy bill which disproportionately taxes high 'tar' brands. Industry should not trade-off ban for bill as both would have virtually the same consumer impact.
- RJR's long term program of developing and testing gradual walk-down of 'tar' for our brands should focus on technology to have all our brands at 17 mgs. or below within two years.

4. When Will It Happen?

Barring unforeseen definitive evidence, probability of ban within ten years is low. Much higher probability of passage of legislation adversely taxing cigarettes having higher 'tar' (e.g., 17+ mgs.). Hart/Kennedy bill defeated

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in Congress in 1976 but expect new effort in this area by mid-1977 as anti-smoking publicity increases based around gas and 'tar' controversy.

5. Sources of Analyses/Forecast/Rationale

- Coordinated efforts of anti-smoking groups with continued support from influential members of Congress such as Senators Kennedy, Hart, and Moss.
- Statistics on drop in alleged "smoking related deaths" by anti's to usage of low 'tar' brands versus high 'tar' U. S. statistics will receive publicity as well as foreign announcements--such as recent U. K. Government announcement on drop in lung cancer deaths which ASH says is attributable to lower 'tar' cigarettes.

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ENDORSEMENT OF "SAFE" CIGARETTE1. Issue

A zero 'tar' cigarette with very low nicotine and gases or a synthetic cigarette (NSM, etc.) is endorsed by the U. S. Government or medical groups as being a "safe" or "risk free" product.

2. What Will Happen?

- Major worldwide publicity generated reaching all smokers.
- Immense government pressure on cigarette makers to drastically reduce 'tar' of all cigarettes possibly accompanied by restrictive tax legislation and/or bans on high 'tar' cigarettes.

3. Impact/Implications

- Immediate consumer demand for such products before major manufacturers able to commercialize the products.
- Dramatic decline in volume of high 'tar' brands accompanied by significant swing to super low 'tar' brands. Catastrophic industry volume losses probably will not occur long-term because of availability of super low 'tar' brands on the market.

4. When Will It Happen?

Very low probability before 1985.

5. Sources of Analyses/Forecasts/Rationale

All published data to date from Anti's speaks to "safer" to smoke low 'tar'. Dr. Gori and others have stated there is no 'safe' cigarette as anything inhaled is dangerous. Medical statistics on zero 'tar' and/or synthetic cigarettes will take years to obtain. Even then, there will be continued controversy over evidence.

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KEY ISSUE POSITION PAPER1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

AN EXTENDED PERIOD OF RELATIVELY SUBNORMAL ECONOMIC GROWTH IS EXPECTED. ADDITIONALLY, THE ECONOMY WILL BE SUBJECT TO PERIODIC RECESSIONARY CONDITIONS IN THE FUTURE.

2. WHAT WILL HAPPEN? THE GROWTH IN REAL GNP IS EXPECTED TO BE ABOUT 3% THROUGH 1981 VS. THE "NORMAL" GROWTH OF 4%. A MILD RECESSION WITH EXPANDED INFLATION IS EXPECTED IN 1978-79. BASED ON HISTORY, A RECESSION IN 1983-85 IS ALSO LIKELY.3. WHAT WILL BE ITS IMPACT/IMPLICATION? ECONOMIC PRESSURES ON CONSUMERS WILL ACCELERATE IN 1978-79 COMPOUNDED BY THE LIKELIHOOD OF SHARPER INCREASES IN CIGARETTE PRICES.

INDUSTRY GROWTH COULD BE DEPRESSED, PUTTING MORE PRESSURES TO INCREASE RJR SHARE TO GAIN VOLUME. INCREASED CONCERN OVER COST COULD RESULT IN EMPHASIS ON VALUE, CENTS OFF, AND LOWER PRICED BRANDS.

4. WHEN WILL IT HAPPEN? 1979 AND 1983-85.5. SOURCES OF ENVIRONMENTAL ANALYSES/FORECASTS AND RATIONALE.

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KEY ISSUE POSITION PAPER

1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.
SLOWDOWN IN THE GROWTH RATE OF SMOKING AGE POPULATION (18+ YEARS OLD).
2. WHAT WILL HAPPEN? SMOKING AGE POPULATION WILL GROW 1.5% ANNUALLY FROM 1975 TO 1985 COMPARED WITH 1.8% ANNUAL GROWTH DURING THE PRIOR 10 YEARS.
3. WHAT WILL BE ITS IMPACT/IMPLICATION?
WILL RESULT IN A LOWER GROWTH RATE FOR INDUSTRY SALES THAN SEEN IN 1965-75.
4. WHEN WILL IT HAPPEN? ACCELERATE FROM 1980 TO 1985. SMOKING AGE POPULATION WILL GROW 1.7% ANNUALLY FROM 1975 TO 1980 AND SLOW TO 1.3% ANNUALLY FROM 1980 TO 1985.
5. SOURCES OF ENVIRONMENTAL ANALYSES/FORECASTS AND RATIONALE.
U.S. GOVERNMENT, DEPARTMENT OF COMMERCE, CENSUS BUREAU.

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POPULATION GROWTH
5 YEAR INCREMENT

ANNUAL GROWTH
(PRIOR FIVE YEARS)

<u>18+</u>	
116.1	-
124.6	+ 1.5%
135.2	+ 1.7%
147.3	+ 1.8%
159.5	+ 1.7%
169.5	+ 1.3%

POPULATION YEARLY GROWTH

<u>18+</u>	
149.7	+ 1.7
152.2	+ 1.7
154.6	+ 1.6
157.1	+ 1.6
159.5	+ 1.5
161.8	+ 1.4
164.0	+ 1.4
166.1	+ 1.3
167.9	+ 1.1
169.5	+ 1.0

1960
1965
1970
1975
1980
1985

1976
1977
1978
1979
1980
1981
1982
1983
1984
1985

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KEY ISSUE POSITION PAPER

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GROUPS
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1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED

POPULATION AGE 30 - 39 WILL GROW DRAMATICALLY BETWEEN
1975 AND 1985.

WHAT WILL HAPPEN?

POPULATION WILL GROW DRAMATICALLY IN THE 30 - 39 AGE GROUPS (UP 42%) WITH SMALLER GROWTH (+23%) FIVE YEARS EITHER SIDE OF THAT AGE GROUP. YOUNGER AND OLDER CATEGORIES WILL SHOW LITTLE TO NO GROWTH DURING THE PERIOD.

WHAT WILL BE ITS IMPACT/IMPLICATION?

SMOKERS IN THEIR 30'S SHOULD PLAY A MORE IMPORTANT ROLE IN MARKETING PLANS. PEER GROUP PRESSURE IS AT A MINIMUM IN THIS AGE CATEGORY, GREATER EMPHASIS WILL BE ON SELECTION OF BRANDS FOR MORE RATIONAL REASONS, AND THE HI-FI/100MM CATEGORY, WHICH PERFORMS WELL IN THIS GROUP, WILL CONTINUE TO SHOW DRAMATIC GROWTH. THIS FAST GROWING AGE SEGMENT WHERE RJR CURRENTLY HAS A POSITION OF STRENGTH, WILL OFFER OPPORTUNITY FOR FUTURE GROWTH FOR THE COMPANY. CONVERSELY PROTECTING OUR SHARE IN THIS AGE GROUP IS CRITICAL.

4. WHEN WILL IT HAPPEN?

POPULATION 25 - 34 WILL INCREASE BETWEEN 1975 - 1980 AND
35 - 49 BETWEEN 1980 - 1985.

5. SOURCE

U.S. BUREAU OF THE CENSUS.

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1960 - 1985

SMOKING AGE POPULATION

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DISTRIBUTION BY AGE

1960	1965	1970	1975	1980	1985	1975 - 1985	
18 - 24	14.0%	16.3%	18.2%	18.7%	18.5%	16.4%	+ .8%
25 - 29	9.4	9.1	10.1	11.5	11.9	12.1	+21.4%
30 - 34	10.3	8.9	8.6	9.5	10.7	11.4	+37.7%
35 - 49	10.7	9.7	8.3	7.9	8.8	10.2	+48.3%
40 - 44	10.1	10.0	8.9	7.6	7.3	8.3	+25.8%
45 - 49	9.4	9.1	9.0	8.0	6.9	6.8	- 2.5%
50+	36.1	36.9	36.9	36.8	35.9	34.8	+ 8.9%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	+15.1%

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KEY ISSUE POSITION PAPER

1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.
THE CIGARETTE INDUSTRY'S FASTEST GROWTH WILL OCCUR IN THE SOUTHERN U. S.
2. WHAT WILL HAPPEN? THE SOUTHERN U. S. WILL SHOW DRAMATIC GROWTH IN CIGARETTE CONSUMPTION AS A RESULT OF GROWTH IN POPULATION AND PER CAPITA CONSUMPTION. WILL RESULT IN INCREASED NUMBER OF RETAIL CIGARETTE OUTLETS - AN OPPORTUNITY.
3. WHAT WILL BE ITS IMPACT/IMPLICATION?
SIGNIFICANTLY INCREASED CIGARETTE CONSUMPTION POTENTIAL, RESULTING IN NEED FOR GREATER ADVERTISING WEIGHT, MORE FIELD SALES MANPOWER, GREATER MERCHANDISING EFFORTS, ETC. COULD HELP RJR BECAUSE OF OUR GREATER PRESENCE IN THE MARKETPLACE. A THREAT BECAUSE OF COMPETITION'S AWARENESS OF OUR SOUTHERN STRENGTH.
MAY LOWER AVERAGE SHIPPING AND WAREHOUSE COSTS AS PERCENT OF TOTAL COSTS.
4. WHEN WILL IT HAPPEN? WILL CONTINUE THROUGH 1985.
5. SOURCE.
PUBLISHED ECONOMIC SURVEYS BY U. S. AND STATE GOVERNMENTS, OUTSIDE PROFESSIONAL CONSULTANTS, AND MRD ANALYSES SHOW SIGNIFICANT ECONOMIC AND POPULATION GROWTH FOR THE SOUTH. MRD ANALYSIS OF STATE TAX DATA SHOWS PER CAPITA CONSUMPTION INCREASING IN THE SOUTH.

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VOLUME (Unadjusted Millions)Avg. Annual
Growth Rate
1975-1985

<u>CENSUS REGIONS</u>	<u>1970</u>	<u>1975</u>	<u>1980</u>	<u>1985</u>	
England	32,051	34,502	35,855	35,876	+ .4
Atlantic	90,536	94,736	101,040	103,070	+ .9
North Central	103,784	113,449	122,042	124,687	+1.0
North Central	38,156	43,274	46,854	50,005	+1.6
South Atlantic	84,451	105,846	111,293	117,980	+1.1
South Central	30,525	40,935	49,028	56,581	+3.8
South Central	44,261	53,800	55,988	60,683	+1.3
Mountain	18,823	24,561	23,862	25,133	+1.2
Pacific	66,136	73,683	75,438	77,091	+ .5
TOTAL U.S.	508,743	584,786	621,400	651,106	+1.1

POPULATION (000's)Avg. Annual
Growth Rate
1975-1985

<u>CENSUS REGIONS</u>	<u>1970</u>	<u>1975</u>	<u>1980</u>	<u>1985</u>	
England	11,873	12,198	12,953	13,528	+1.1
Atlantic	37,271	37,263	40,082	41,651	+1.2
North Central	40,368	40,979	44,004	45,809	+1.2
North Central	16,367	16,690	17,064	17,539	+ .5
South Atlantic	30,772	33,715	35,606	38,281	+1.4
South Central	12,823	13,544	14,240	14,958	+1.0
South Central	19,397	20,855	20,760	21,746	+ .4
Mountain	8,345	9,644	9,351	9,917	+ .3
Pacific	26,589	28,234	29,469	31,039	+1.0
TOTAL U.S.	203,805	213,122	223,529	234,468	+1.0

PER CAPITA CONSUMPTIONAvg. Annual
Growth Rate
1975-1985

<u>CENSUS REGION</u>	<u>1970</u>	<u>1975</u>	<u>1980</u>	<u>1985</u>	
England	2,699.5	2,828.5	2,768.1	2,652.0	- .1
Atlantic	2,429.7	2,542.4	2,520.8	2,474.6	- .3
North Central	2,570.9	2,768.5	2,773.4	2,721.9	- .2
North Central	2,331.3	2,592.8	2,745.8	2,851.1	+1.0
South Atlantic	2,744.4	3,139.4	3,125.7	3,081.9	- .2
South Central	2,380.5	3,022.4	3,443.0	3,782.7	+2.5
South Central	2,281.8	2,579.7	2,696.9	2,790.5	+ .8
Mountain	2,255.6	2,546.8	2,551.8	2,534.3	- .0
Pacific	2,487.3	2,609.7	2,559.9	2,463.7	- .5
TOTAL U.S.	2,496.2	2,743.9	2,780.0	2,777.0	+ .1

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KEY ISSUE POSITION PAPER1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

BLACK WILL BECOME A MORE IMPORTANT SEGMENT OF THE CIGARETTE BUSINESS.

2. WHAT WILL HAPPEN? BLACK POPULATION OF SMOKING AGE WILL GROW FASTER THAN TOTAL POPULATION, AND KOOL'S HOLD ON PREFERENCES SHOULD WEAKEN - AN OPPORTUNITY.

BLACKS ARE CURRENTLY 10.3% OF 18+ POPULATION AND ACCOUNT FOR ABOUT 9% OF CIGARETTE INDUSTRY VOLUME. IN 1985, BLACKS WILL BE 12.3% OF 18+ POPULATION AND ACCOUNT FOR 11 - 12% OF INDUSTRY VOLUME.

KOOL'S SHARE OF THE BLACK MARKET (CURRENTLY 24.4%) SHOULD PEAK WITHIN THE NEXT TWO YEARS AND THEN DECLINE. HISTORY SUGGESTS ANOTHER BRAND WILL EMERGE AS "THE BRAND" FOR BLACKS -- AN OPPORTUNITY.

3. WHAT WILL BE ITS IMPACT/IMPLICATION? INCREASED OPPORTUNITY FOR BLACK MARKET BUSINESS, PARTICULARLY IN LONGER AND MENTHOL CIGARETTES. THE BREAKDOWN OF KOOL'S PEER GROUP INFLUENCE OPENS THE DOOR FOR ANOTHER BRAND TO EVENTUALLY DOMINATE THE BLACK MARKET. REQUIRES LEARNING MORE ABOUT BLACK SMOKERS' WANTS AND DESIRES.

BLACKS ARE A LARGER PERCENT OF THE POPULATION IN THE KEY RJR MARKETING AREAS OF METRO AND THE FAST GROWING SOUTH.

4. WHEN WILL IT HAPPEN? THROUGH 1985. CONTINUES AN EXISTING TREND.5. SOURCES:

U.S. GOVERNMENT, DEPARTMENT OF COMMERCE, BUREAU OF CENSUS POPULATION PROJECTIONS. RJR MRD BLACK AUDITS.

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POPULATION 18+ - BLACK VS. WHITE

	1965	1970	1975	1980	1985
<u>WHITE</u>					
POPULATION	111.5	120.3	130.1	139.8	147.4
ANNUAL GROWTH		+ 1.6%	+ 1.6%	+ 1.5%	+ 1.5%
DISTRIBUTION	90.4%	90.1%	89.7%	89.2%	88.7%
<u>BLACK</u>					
POPULATION	11.9	13.2	15.0	16.9	18.7
ANNUAL GROWTH		+ 2.2%	+ 2.7%	+ 2.5%	+ 2.1%
DISTRIBUTION	9.6%	9.9%	10.3%	10.8%	11.3%

KOOL'S SHARE OF BLACK MARKET

	1972	1974	1975	1976
SHARE OF MARKET	19.8	21.5	24.0	24.4
CHANGE FROM PRIOR YEAR		+1.7%	+2.5%	+1.4%

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BLACK % OF TOTAL POPULATION

- DISTRIBUTION -

	<u>1970</u>
NORTHEAST	3.3
HA	10.6
ENC	9.6
WNC	4.3
SA	20.9
ESC	20.1
WSC	15.6
MOUNTAIN	2.2
PACIFIC	<u>5.7</u>
TOTAL U.S.	11.1

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KEY ISSUE POSITION PAPER1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

FEMALES WILL CONTINUE TO BECOME A MORE IMPORTANT PORTION OF THE SMOKING POPULATION.

2. WHAT WILL HAPPEN? FEMALES WILL INCREASE FROM 46% OF ALL SMOKERS IN 1975 TO 48% BY 1980 -- AN OPPORTUNITY. THIS RESULTS FROM AN EXPECTED SLOWER DECLINE IN INCIDENCE AMONG FEMALES COMPARED TO MALES.3. WHAT WILL BE ITS IMPACT/IMPLICATION?

WANTS AND DESIRES OF FEMALES WILL HAVE TO BE CONSIDERED MORE AND MORE IN MARKETING ACTIONS. ALSO, INCREASED EMPHASIS ON THE CHANGING ROLES OF WOMEN BEYOND THAT OF WIFE, HOMEMAKER, AND MOTHER CONTINUE.

4. WHEN WILL IT HAPPEN? CURRENT TREND.5. SOURCE:

SOURCES INCLUDE CONSUMER DATA AND VARIOUS STUDIES ON INCIDENCE. RATIONALE ASSUMES THAT INCIDENCE AMONG WOMEN WILL CONTINUE ITS TREND OF DECLINING AT A SLOWER RATE AMONG FEMALES COMPARED TO THE DECLINE AMONG MALES.

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SMOKERS - % MALE/FEMALE

	1955	1968	1972	1976	1980	1985
MALE	65%	57%	55%	54%	52%	52%
FEMALE	35	43	45	46	48	48

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1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

ADULT SMOKERS UNDER 25 WILL SHOW A MAJOR SHIFT IN BRAND PREFERENCE.

2. WHAT WILL HAPPEN? THE DECLINE IN MARLBORO'S SHARE OF UNDER 25 SMOKERS WILL CONTINUE OPENING THIS SEGMENT OF THE MARKET FOR ANOTHER DOMINANT BRAND TO EMERGE FROM PEER GROUP PRESSURES. A RECENTLY INTRODUCED OR YET TO BE INTRODUCED BRAND WILL SHOW SUBSTANTIAL SHARE GROWTH IN THE UNDER 25 MARKET.

WHAT WILL BE ITS IMPACT/IMPLICATION?

THE COMPANY MARKETING A BRAND MEETING UNDER 25 YEAR OLD SMOKERS' WANTS AND DESIRES WILL DOMINATE SHARE OF MARKET GROWTH. REQUIRES THAT WE PAY CLOSE ATTENTION TO THIS MARKET IN OUR NEW BRAND PLANNING AND CAREFULLY TRACK THE IN-MARKET ACCEPTANCE BY SMOKERS UNDER 25 OF NEW BRANDS WITH POTENTIAL TO PENETRATE THIS MARKET SEGMENT.

4. WHEN WILL IT HAPPEN? THE OPPORTUNITY IS NOW. THE VOLUME GROWTH SHOULD CONTINUE THROUGH 1985.

5. SOURCE.

NFO, SHARE OF SMOKERS, SHOWS THAT MARLBORO'S ACCEPTANCE AMONG 14 - 17 YEAR OLDS HAS DROPPED FROM 39% TO 32%. THIS PATTERN HAS BEEN REPEATED BY THREE BRANDS WITH PALL MALL PEAKING IN 1969, TOTAL WINSTON IN 1970, AND TOTAL MARLBORO SHOULD PEAK SHARE IN 1978.

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1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

MENTHOL AND EXTRA LONG CIGARETTES WILL CONTINUE TO GROW, BUT THIS GROWTH WILL BE CONCENTRATED IN THE HI-FI CATEGORY.

2. WHAT WILL HAPPEN? IN 1985, THE MENTHOL CATEGORY WILL ACCOUNT FOR 32.5% OF THE MARKET, A GAIN OF 4.7 SHARE POINTS OVER 1975. THIS GROWTH IS DUE TO AN INCREASE IN HI-FI MENTHOLS OF 10.8 SHARE POINTS (2.8% - 13.6%) WHILE FULL AND MIDDLE FLAVOR MENTHOLS DECLINE IN SHARE.

EXTRA LONG CIGARETTES (100MM+) WILL GAIN 9.2 SHARE POINTS. ALL OF THIS GAIN COMES FROM 100MM+ HI-FI'S.

3. WHAT WILL BE ITS IMPACT/IMPLICATION? MAJOR NEW BRAND EMPHASIS WILL HAVE TO CONCENTRATE ON BOTH THESE CATEGORIES. PHILIP MORRIS, OR MAJOR COMPETITION, WILL IN ALL PROBABILITY BE ENTERING THESE MARKETS WITH BOTH A HI-FI 100MM AND/HI-FI MENTHOL ONLY PRODUCT.4. WHEN WILL IT HAPPEN? CURRENT TREND.5. SOURCE:

ANALYSIS OF PAST AND CURRENT BRAND AND CATEGORY PERFORMANCE. RATIONALE IS BASED ON EXPECTED GROWTH IN THE HI-FI CATEGORY RESULTING FROM INCREASES IN THE HEALTH CONTROVERSY AND RJR NEW PRODUCT PLANS.

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SHARE OF MARKET

	<u>1975</u>	<u>1980</u>	<u>1985</u>
TOTAL MENTHOL	27.8	30.6	32.5
HI-FI MENTHOL	2.8	8.9	13.6
TOTAL 100MM+	24.9	30.0	34.1
HI-FI 100MM+	.9	5.1	10.1

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1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

RJR AND PHILIP MORRIS WILL BE THE ONLY CIGARETTE COMPANIES SHOWING SHARE GROWTH.

2. WHAT WILL HAPPEN?

REYNOLDS AND PHILIP MORRIS WILL SHOW SHARE GROWTH BETWEEN NOW AND 1985 AT THE EXPENSE OF THE OTHER COMPANIES. RJR WILL CONTROL 38.0% OF THE MARKET IN 1985 COMPARED TO PHILIP MORRIS' 30.6%. TOGETHER THESE TWO COMPANIES WILL HAVE OVER TWO THIRDS OF THE MARKET.

3. WHAT WILL BE ITS IMPACT/IMPLICATION?

FOR THIS GROWTH TO OCCUR, BOTH RJR AND PM WILL BE LARGELY DEPENDENT ON SUCCESSFUL NEW BRAND INTRODUCTIONS IN THE HI-FI CATEGORY. PM WILL ATTEMPT TO CORRECT ITS MENTHOL WEAKNESS. RJR NEW BRANDS, IN PART, MUST BE DESIGNED TO PREEMPT PHILIP MORRIS' GROWTH.

4. WHEN WILL IT HAPPEN? CURRENT TREND.

5. SOURCE

SOURCES INCLUDE AN EXAMINATION OF CURRENT AND PAST INDIVIDUAL NEW BRAND AND COMPANY PERFORMANCE WITH EXPECTATIONS OF FUTURE NEW BRAND INTRODUCTIONS. RATIONALE IS BASED ON ABILITY OF TWO COMPANIES TO GAIN SHARE OF MARKET AND TO SUCCESSFULLY INTRODUCE NEW BRANDS IN THE FUTURE AS THEY HAVE IN THE PAST.

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SHARE OF MARKET

	1975	1980	1985
RJR	33.0%	36.0%	38.0%
P. MORRIS	23.6	28.4	30.6
B&W	17.5	15.8	14.8
AMERICAN	13.7	10.6	9.5
LORILLARD	7.6	6.3	5.2
L&M	4.3	2.9	1.9

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KEY ISSUE POSITION PAPER1. TREND, ISSUE, OR EVENT IDENTIFIED/DESCRIBED.

LIFESTYLES AND VALUES WILL CONTINUE TO CHANGE WITH THE CONTINUED BREAKDOWN OF TRADITIONALISM AND GROWTH FOCUSED ON SELF-REALIZATION.

2. WHAT WILL HAPPEN? MAJOR TRENDS CONTINUING OR EMERGING INCLUDE:

- A. MORE EMPHASIS ON THE BASIC ASPECTS OF PHYSICAL WELL-BEING (HEALTH, VIGOR); A STATIC OR EVEN DECLINING CONCERN WITH THE COSMETIC OR APPEARANCE-ONLY ASPECTS. YOUTH WILL CONTINUE ITS TRADITIONAL COMMITMENT TO APPEARANCE ENHANCEMENT, OLDER PEOPLE WILL FOCUS ON HEALTH, FITNESS, AND LESS ON PURELY COSMETIC.
- B. COMMITMENT TO UNIQUE, INDIVIDUAL SELF-EXPRESSION WILL CONTINUE TO GROW. OVERT SYMBOLS OF NONCONFORMITY WILL BE LESS NECESSARY. PERSONAL EXPRESSION WILL BECOME LESS RISKY, MORE OF A BALANCE BETWEEN WHO ONE IS AND HOW ONE SHOULD ADJUST TO OUTSIDE REALITIES.
- C. CONTINUED FUTURE EROSION OF THE IMPORTANCE OF MONEY AND POSSESSIONS PER SE. LARGE PROPORTIONS OF YOUTH MAY EMBRACE A GOALLESS VALUES SYSTEM.
- D. CONTINUED DRIVE TOWARD SELF-FULFILLMENT WHICH CONTRIBUTES TO THE EROSION IN THE IMPORTANCE OF MONEY AND POSSESSIONS PER SE. PERSONAL ACHIEVEMENT AND SELF WORTH WILL BE SOUGHT IN THE WORK SITUATION.
- E. CONTINUED WEAKENING OF CLASSICAL FAMILISM ON TRADITIONALLY DEFINED SEX AND SIBLING ROLES.
- F. INCREASES IN HUNGER FOR THE NATURAL, THE REAL, THE GENUINE, THE AUTHENTIC, AT LEAST NEAR TERM.
- G. INCREASING DEEMPHASIS OF SYSTEM/ORDER IN LIFESTYLES WITH EASING UP OF SCHEDULES, TIMETABLES FOR LIVING ONE'S DAILY LIFE, WHILE SEEKING VARIETY, CHANGE, AND EXCITEMENT.

3. WHAT WILL BE ITS IMPACT/IMPLICATION? THESE TRENDS WOULD SUGGEST:

- A. THE NEED TO FOCUS ON REAL (IMPORTANT) PRODUCT BENEFITS, NOT JUST ANOTHER WAY OF GIVING THE SAME THING.
- B. CONCENTRATION ON REAL OR LASTING VALUE AND APPEARANCE, NOT JUST TRENDY OR FLIGHTY FASHION.
- C. CONSUMERS WILL SEEK EVEN MORE PRODUCTS WITH REAL VALUE AND MEANING TO ONE'S SELF AS A PROJECTION OF ONE'S REAL SELF.
- D. INCREASED EMPHASIS ON HEALTH WILL PLAY A MAJOR ROLE IN MORE RATIONAL BUYING BEHAVIOR.

4. WHEN WILL IT HAPPEN? CURRENT AND EMERGING TRENDS..5. SOURCE: YANKELOVICH MONITOR ON LIFESTYLES AND VALUES.

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AVAILABILITY OF SPACE1. Trend/Issue/Event

Advertising impact per exposure is deteriorating/being limited in all media forms.

2. What Will Happen?

- Advertiser will place more emphasis on competitive "clutter" in selecting media vehicles - avoiding those that rate high
- Media will place self-imposed limitation on cigarette advertising volume that is accepted.

3. What Will Be Its Impact/Implications?

- Page units in magazines will no longer be "standard" opportunity.
- Attempts may be made to charge tobacco advertisers a premium price - threat.
- Newspapers, in some form, to become more as vehicle.
- Alternative media forms must be found to fulfill total Corporate demand - opportunity.
- System must be developed to most efficiently allocate scarce inventories of existing media consistent with Corporate/Brand objectives.

4. When Will It Happen?

- It's happening now.
- Trend in standard O-O-H (30-sheet and paint) to be acute by 1980.
- Trend in printed media, principally magazines and supplements, to accelerate and become acute by 1980-85.

5. Sources:

MRD studies; historical experience with some media; discussions with selected media management.

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ADVERTISING MEDIA COST INCREASES

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1. Trend/Issue/Event

Cost per unit of print media exposure opportunities will increase more rapidly than general inflation rate.

2. What Will Happen?

- Costs will rise out of proportion to circulation due to:
 - undersupply of material - paper and petroleum based ink.
 - greater number of smaller circulation, less efficiently producible vehicles.
 - higher distribution costs, currently via Postal Service.

3. What Will Be Its Impact/Implication?

- Specific segments of the population can be reached in a concentrated manner - opportunity.
- Population segments of high potential must be defined and concentrated against - opportunity.
- Broad total consumer reach can be achieved only with an increase in cost-per-thousand cigarettes applied against advertising - threat.

4. When Will It Happen?

- Trend will continue at an accelerating pace into the 1980's.

5. Sources:

Industry cost trends; Magazine Publishers Association and American Newspaper Publishers Association; current Agency forecasts.

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1. Trend/Issue/Event

Improvement in health technology will proceed in a number of areas which may have implications for the tobacco industry.

2. What Will Happen?

One or none of the following:

- Incontrovertible evidence supporting the smoking/health links
- Incontrovertible evidence denying the smoking/health links
- Isolation and elimination of asserted carcinogenic elements in smoke
- Cure for diseases allegedly related to smoking
- Development of reliable "quit" techniques
- Identification of dozens of other suspected carcinogenics.

What Will Be Its Impact/Implication?

- Impact may range from elimination of concern about smoking to vastly increased concern coupled with ready ability to quit.
- Development of products alleged to be less hazardous - new filtration system, new strains of tobacco, tobacco substitution/flavorings which would reduce levels of suspected noxious substances.

4. When Will It Happen?

Possibility of dramatic development at any time with probability increasing over time.

5. Sources:

Medical and Psychological Journals, Media press releases, health organization and governmental releases.

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Product to protect the consumer

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1. Trend/Issue/Event

Of the six major producers, only RJR and Philip Morris are achieving growth in the tobacco business.

2. What Could Happen?

- RJR & PM will share 80% of the business.
- Brown & Williamson and Lorillard will dominate the remaining 20% of the market.
- American Tobacco and Liggett & Myers will cease to be factors in the cigarette business.

What Will Be Its Impact/Implication?

- Possible anti-trust perils are cause for concern.
- Only the two leaders will be able to afford the absolutely major commitment required to launch new entries successfully.

When Will It Happen?

1980 will see the trend substantially materialized and it will continue through the 1980's.

Sources:

Past, current and forecasted cigarette company performance.

The growing trend to giantism and to oligarchy in all business throughout the world, documented in business press.

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NON-TOBACCO CIGARETTE1. Trend/Issue/Event

Development of a consumer-acceptable non-tobacco-based cigarette.

2. What Will Happen?

Cigarette smoking will increase significantly.

3. What Will Be Its Impact/Implication?

Proliferation of competitive entries from industry segments not now in tobacco or tobacco-related business.

4. When Will It Happen?

After 1980.

5. Sources

Task Force on Tobacco and Cancer, Agricultural Economic Research, U.S. Department of Agriculture. "Use of Tobacco, Practices, Attitudes, Knowledge and Beliefs in the United States," Department of Agriculture.

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ANTI-SMOKING TECHNOLOGY

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1. Trend/Issue Event

There could be a technological breakthrough, either a drug or clinical procedure, that will aid people in quitting smoking more easily.

2. What Will Happen?

There currently are many over-the-counter drugs, mechanical devices, etc. which are promoted as being effective in reducing or stopping smoking. This trend will continue and, on judgment, it is felt many manufacturers are devoting research and development efforts against such products.

3. What Will Be Its Impact/Implication?

While data are not available on the percentage of the smoking population who would like to reduce or quit, it is believed, on judgment, to be relatively large. While many persons quit without difficulty, there are others who do not. A technological breakthrough, heavily advertised and promoted, would have a major negative impact on consumption.

4. When Will It Happen?

As it is assumed companies are working on such a product, it could happen at any time.

5. Sources

Media press releases, advertising for anti-smoking products, clinics, etc.

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PRICE ELASTICITY1. Trend/Issue/Event

Cost of cigarettes may be elastic, either on an absolute basis or relative to general inflation rate.

2. What Will Happen?

Increased costs of product to consumer as a result of higher manufacturer's cost, retail margins, tax burden or a combination of these will continue to increase consumer price of cigarettes, possibly at a greater rate than general inflation rate.

3. What Will Be Its Impact/Implication?

- Current smokers/new smokers will be forced/kept out of the market on pure economic reasons.
- Corporate profit margins will be jeopardized to remain within inelastic range or,
- Absolute sales/profit will fall below long-term goals.

4. When Will It Happen?

Unknown

5. Sources

Wall Street Transcript, General Economic Forecasts, Internal Discussions.

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COMPETITION FROM FOREIGN MARKETERS1. Trend/Issue/Event

Foreign marketers increase activity in U.S. market.

2. What Will Happen?

Foreign marketers will turn to U.S. for outlet of smoking products. Availability of cheaper raw materials could sharpen competition in U.S.

3. What Will Be Its Impact/Implication?

Reduction of share of American products in U.S. markets.

4. When Will It Happen?

Probably long term within the next 10 years.

5. Sources

Tobacco Reporter. Business Week, David Owen (U.K. Health Minister).

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ENFORCEMENT PRACTICES1. Trend/Issue/Event

Stronger enforcement of laws prohibiting sales of cigarettes to teen-agers.

2. What Will Happen?

Public opinion will mandate that current laws prohibiting sale of cigarettes to teen-agers be enforced.

3. What Will Be Its Impact/Implication?

Reduction in the number of new smokers.

4. When Will It Happen?

By the 1980's.

5. Sources

"Teenage Smoking, National Patterns of Cigarette Smoking, Ages 12 through 18, in 1968 and 1970", Department of Health, Education and Welfare.

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Qualitative	Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	10%/Yr.	Survival		
Increased health concern about smoking.					X	+	-	<ul style="list-style-type: none"> Increased demand for cigarettes that are perceived to alleviate the health concern (e.g., low 'tar') + Reduced demand for higher 'tar' cigarettes (full-flavor, middle flavor) - Continued decline in smoking incidence and per capita consumption resulting from fewer new smokers and/or more quitters. - 	1977

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+ = opportunity

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- - threat
+ + opportunity

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Earliest Possible Year of Occurrence	Qualitative	Quantitative		Probability of Occurrence					Key Issues
		Effect on Sales/Profits	10X/Yr. Survival	10X	30X	50X	70X	90X	

1977
Total consumption decline due to
lower incidence and per capita
consumption among smokers.

X

Decline in the social
acceptability of
cigarette smokers
and smoking.

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)*		Earliest Possible Year of Occurrence
	10X	30X	50X	70X	90X	Qualitative				
						10X/Yr.	Survival			
Further governmental imposed restrictions on advertising, promotion and labeling.			X			-		<ul style="list-style-type: none">• Reduced ability to deliver effective advertising and promotion programs to consumers.• Reduced competitiveness within industry.• Greater reliance on Field Sales resources for competitive advantage.	1978	

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+ = opportunity
- = threat

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threat - -
opportunity - +

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits	10X/Yr. Survival	Qualitative	Earliest Possible Year of Occurrence
	10X	30X	50X	70X	90X				
Threat of a graduated Federal excise tax on cigarettes based on T & N levels.	X					+		Lower retail price on lower T & N brands would encourage increased consumption. Higher price on high 'tar' brands would decrease demand.	

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PRIORITY SUMMARY OF KEY ISSUES/IMPACT IMPLICATIONS: MARKETING DEPARTMENT

1977-

Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)*	Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	Qualitative			
						10%/Yr.	Survival		
Hi-Fi cigarettes (14 mgs. and less) being largest cigarette volume category.					X	+		<ul style="list-style-type: none">• Lowered 'tar' levels on established brands..• Significant new brand opportunities.• Decline in smoking satisfaction and unit volume growth.	1985-- but imp of trend causes definite action 1976 and beyond.

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- = threat
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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)*		Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	Qualitative				
						10%/Yr.	Survival			
Carbon monoxide singled out as harmful ingredient and publicized by government and anti's.					X	-		<ul style="list-style-type: none">• Significant increase in consumer concern.• Decline in cigarette unit volume growth.• Mandatory CO labeling on package and advertising.• FTC reports CO levels.• Reduced CO levels on established brands.• New brands feature low CO (low gas) as primary benefit.		1978

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)*		Earliest Possible Year of Occurrence
	10X	30X	50X	70X	90X	Qualitative				
						10X/Yr.	Survival			
Government ban on high 'tar' cigarettes.		X						NEGATIVE EFFECT <ul style="list-style-type: none">"Scare" reduces unit volume growth of industry.Established brands immediately reduce 'tar' levels of brands affected by ban.Restrictive taxation follows.	1985	

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PRIORITY SUMMARY OF KEY ISSUES/IMPACT IMPLICATIONS: MARKETING DEPARTMENT

1977-1985

Key Issues	Probability of Occurrence					Quantitative: Effect on Sales/Profits		Estimated Impact Implications (+ or -)*	Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	Qualitative			
						10%/Yr.	Survival		
Endorsement of safe cigarette.	X					+		<ul style="list-style-type: none">• Significant swing to these products as well as sudden and dramatic shift to super low 'tar' brands.• Accelerated reduction of 'tar' on established brands.• Restrictive taxation results on higher 'tar' brands.	1985

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PRIORITY SUMMARY OF KEY ISSUES/IMPACT IMPLICATIONS: MARKETING DEPARTMENT

1979-1989

Key Issues	Probability of Occurrence					Estimated Impact Implications (+ or -)		Earliest Possible Year of Occurrence	
	100	300	500	700	900	Quantitative: Effect on Sales/Profits			
						10%/Year	Survival		
I. Recession in 1978-1979 and in 1983-1985.				X		-		<ul style="list-style-type: none">Increased economic pressures on consumers and sharper increases in cigarette prices.Industry growth depressed putting more pressure to increase RJA share to gain volume.Increased concern over cost could result in emphasis on value, cents off, and lower priced brands.	1978
II. Slowdown in the growth rate of smoking age population.					X	-		<ul style="list-style-type: none">Lower growth rate for industry sales than seen in 1965-1975.	1976
III. Population aged 30-39 will grow dramatically between 1975 and 1985.					X	+		<ul style="list-style-type: none">Smokers in 30's will play a more important role in marketing plans.Greater emphasis on selection of brand for more rational reasons.RJA has position of strength but will need to protect from competitive intrusion.	1976
IV. The Southern U. S. will show the fastest growth in industry volume.					X	+		<ul style="list-style-type: none">Significantly increased cigarette consumption resulting in need for greater advertising weight, more field sales manpower, greater merchandising efforts, etc.Could help RJA because of our greater presence in the market place.A threat due to competitive awareness of RJA's Southern strength.Should lower average shipping and warehousing costs.	1976
V. Blacks will become a more important segment of the cigarette business.					X	+		<ul style="list-style-type: none">Increased opportunity for black market business particularly in longer and menthol cigarettes.Breakdown of Kool's peer group influence opens door for another brand to dominate.Requires more knowledge of Blacks' wants/desires.Blacks are larger percent of the population in key RJA marketing areas of metro and the fast growing South.	1976

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PRIORITY SUMMARY OF KEY ISSUES/IMPACT IMPLICATIONS, MARKETING DEPARTMENT

1979-1989

Key Issues	Probability of Occurrence					Estimated Impact Implications (+ or -)		Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	Quantitative: Effect on Sales/Profits		
						18%/Year	Survival	
VI. Females will continue to become a more important portion of the smoking population.					X	+	<ul style="list-style-type: none">Greater consideration must be given to wants and desires of females.Increased emphasis on changing roles of women beyond that of wife, homemaker, and mother.	1976
VII. Adult smokers under 35 will show a major shift in brand preference.					X	+	<ul style="list-style-type: none">The Company marketing a brand meeting under 35 year old smokers' wants and desires will dominate share of market growth.Requires close attention to this market in new brand planning and tracking of new brands potential to penetrate this market.	1976
VIII. Menthol and extra long cigarettes will continue to grow, but this growth will be concentrated.				X		+	<ul style="list-style-type: none">Major new brand emphasis will have to concentrate on both these categories.Philip Morris, or major competition, will, in all probability, be entering these markets with both a hi-fi 100mm and a hi-fi menthol only product.	1976

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PRIORITY SUMMARY OF KEY ISSUES/IMPACT IMPLICATIONS: MARKETING DEPARTMENT

1979-1989

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -) ^A		Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	10%/Yr.	Survival	Qualitative		
Limitation*/Deterioration** of impact				x*	x**	±		<ul style="list-style-type: none">Page units in magazines will no longer be "standard" - opportunityAttempts may be made to charge tobacco advertisers a premium price - threatNewspapers, in some form, to become more as vehicleAlternative media forms must be found to fulfill total Corporate demand - opportunitySystem must be developed to most efficiently allocate scarce inventories of existing media consistent with Corporate/Brand objectives.	1976** 1980"	
Increase in cost per unit of media exposure			x			±		<ul style="list-style-type: none">Specific segments of the population can be reached in a concentrated manner - opportunityPopulation segments of high potential must be defined and concentrated against - opportunityBroad total consumer reach can be achieved only with an increase in cost-per-thousand cigarettes applied against advertising - threat	1978-1980	

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A + = opportunity
 - = threat

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)*		Earliest Possible Year of Occurrence
								Qualitative		
	10%	30%	50%	70%	90%	10%/Yr.	Survival			
Improvement in Health Technology	x x					+		. Elimination of concern about smoking (+) . Increased concern with more ready ability to quit (-) . Development of products alleged to be less hazardous (+)		1980
RJR/PM controlled Tobacco Industry	x	x			x	+		. Possible anti-trust perils (-) . Required financial commitment for new brands affordable only to two major companies (+)		1985
Development of consumer acceptable non-tobacco base cigarette		x				-	x	. Proliferation of competitive entries from industry segments not now in tobacco or tobacco-related business		
A technological breakthrough, either a drug or clinical procedure, that will allow people to quit smoking more easily			x					. A technological breakthrough, heavily advertised and promoted, would have a major negative impact on consumption.		1980

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)*		Earlier Possible Year of Occurrence
	10%	30%	50%	70%	90%	Qualitative				
						10%/Yr.	Survival			
Cost of cigarettes may be elastic, either on an absolute basis or relative to general inflation rate.			x			-		<p>CONFIDENTIAL</p> <ul style="list-style-type: none">- Current smokers/new smokers will be forced/kept out of the market on pure economic reasons.- Corporate profit margins will be jeopardized to remain within inelastic range or,- Absolute sales/profit will fall below long-term goals.	Unknown	

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Estimated Impact Implications (+ or -)		Earliest Possible Year of Occurrence
								Qualitative		
	10%	30%	50%	70%	90%	10%/Yr.	Survival			
Foreign marketers increase activity in U.S. market	x					-		possible reduction in share of American products in U.S. market		1978
Stronger enforcement of laws prohibiting sales of cigarettes to teenagers			x			-		Reduction in number of new smokers.		1980

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KEY ISSUES OF R. J. REYNOLDS TOBACCO COMPANY

Internally Oriented

1. Product Satisfaction
2. Resource Development and Allocation
3. Market Segment Performance
4. Organization Performance

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Product Satisfaction

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1. Trend/Issue Event

Consumer demand for hi-filtration cigarettes is increasing at an accelerating rate. Manufacturers have a limited ability to provide satisfaction in lower 'tar' and nicotine products.

2. What Will Happen?

If this trend continues, hi-filtration products are expected to account for approximately 28% of all cigarettes sold by 1980 and 42% by 1985.

3. What Will Be Its Impact/Implication?

RJR will be unable to achieve its share of market goals unless we can develop low 'tar' and nicotine products that deliver sufficient taste to satisfy consumer wants.

4. When Will It Happen?

1977-1985.

5. Sources

MRD studies, marketing analyses and competitive actions.

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Resource Development and Allocation1. Trend/Issue Event

As consumer wants are identified in a more finite manner and products to meet those needs are developed, the options for use of finite Company resources will increase dramatically.

2. What Will Happen?

Our need to identify and prioritize problems/opportunities will increase, and our ability to solve or capitalize on all but the critical ones will be increasingly limited.

3. What Will Be Its Impact/Implication?

The likelihood of achieving our ambitious business goals will be jeopardized.

4. When Will It Happen?

It is happening now and will accelerate in direct proportion to the magnitude of share of market increases we wish to achieve.

5. Sources

Management seminars and plans, on-the-job observations and business/financial forecasts.

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Market Segment Performance

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1. Trend/Issue Event

Philip Morris has succeeded in the recent past of capturing the predominant share of smokers 18-24 years old.

2. What Will Happen?

PM could become the market leader if these smokers retain their loyalty to PM brands as they grow into the "prime smoking group" of 25-34 years.

3. What Will Be Its Impact/Implications?

RJR will lose its leadership position.

4. When Will It Happen?

Late 1980's.

5. Sources

MRD studies.

Product to be protected order

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Organization Performance1. Trend/Issue Event

RJR's marketing organization continues to expand in relationship to the growth in the number of our brands and the increasing complexity of our business.

2. What Will Happen?

If provisions are not made to appropriately plan for future organizational needs and to properly hire and train managers, we will be unable to cope with future challenges.

3. What Will Be Its Impact/Implication?

The prospect of achieving our business goals is substantially diminished.

4. When Will It Happen?

On-going.

5. Sources

Business plans, organizational surveys and workshops, personnel potential reviews and succession plans.

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KEY ISSUES OF R. J. REYNOLDS TOBACCO COMPANYExternally Oriented

1. Consumer Health Concerns - Increased health concerns about cigarette smoking from both smokers and non-smokers.
2. Social Acceptability of Cigarettes - Cigarette smoking and the cigarette smoker are being damned by the government, media and crusading non-smokers.
3. Marketing Restraints - Increasing threat of greater governmental imposed restrictions on cigarette advertising copy, media usage, labeling, and trial incentives.
4. Graduated Cigarette Tax (Based on T & N Levels) - Threat of a new Federal excise tax based on 'tar' and nicotine levels.
5. Industry Trend Toward Low-'Tar' Cigarettes - Cigarettes having 14 mgs. 'tar' and less become the largest volume category in the industry.
6. Carbon Monoxide - Widespread consumer publicity alleging harmful effects of carbon monoxide and other gases in cigarettes.
7. Government Ban on High-'Tar' Cigarettes - Possible government ban on cigarettes having over a certain level of 'tar'.
8. Endorsement of "Safe" Cigarette - For example, a zero 'tar' cigarette with very low nicotine and gases or a synthetic cigarette (NSM, etc.) is endorsed by the U. S. Government or medical groups as being a "safe" or "risk free" product.
9. Recession in 1978-1979 and in 1983-1985
10. Slowdown in the Growth Rate of Smoking Age Population
11. Population Aged 30-39 Will Grow Dramatically Between 1975 and 1985
12. The Southern U. S. Will Show the Fastest Growth in Industry Volume
13. Blacks Will Become a More Important Segment of the Cigarette Business
14. Females Will Continue to Become a More Important Portion of the Smoking Population

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Key Issues	Probability of Occurrence					Quantitative Effect on Sales/Profits		Qualitative Impact	Earliest Possible Year of Occurrence
	10%	30%	50%	70%	90%	10%/Yr.	Survival		
Product Satisfaction					x		±	<ul style="list-style-type: none"> RJR will be unable to achieve its share of market goals unless we can develop low 'tar' and nicotine products that deliver sufficient taste to satisfy consumer wants. 	1977-1985
Resource Development & Allocation					x		±	<ul style="list-style-type: none"> What is the level of advertising/promotion spending required to maximize volume <ul style="list-style-type: none"> - by brand - by brand style - new vs. established What is the most productive allocation of marketing funds for each brand <ul style="list-style-type: none"> - geographically - demographically How do we maximize the use of finite resources <ul style="list-style-type: none"> - media space - display/shelf space 	Happening Now
Market Segment Performance			x				±	<ul style="list-style-type: none"> RJR will lose its leadership position. 	Late 1980's
Marketization Performance			x				±	<ul style="list-style-type: none"> The prospect of achieving our business goals is substantially diminished. 	On-going

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- opportunity
- threat

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PUBLIC SMOKING

In 1971, Jesse L. Steinfeld, M.D., then U.S. Surgeon General, advocated the prohibition of smoking in confined public places, such as restaurants, theaters, airplanes, trains and buses, because the nonsmoker might be injured by ambient tobacco smoke (i.e., tobacco smoke in the atmosphere).

Steinfeld's statement gave anti-smoking groups an effective theme. The anti-smoking organizations adopted the objective that smoking should be made socially unacceptable. They began a mass invasion of state capitals and city halls to argue that laws must be enacted to protect the nonsmoker from ambient tobacco smoke forced on him by smokers in public places.

CHRONOLOGY

The following is a brief sketch of major events at the state and local level subsequent to Steinfeld's clarion call.

- 1970 Ten bills introduced to restrict smoking in public places; none enacted.
- 1971 Twenty-eight bills introduced in five states; two enacted.
- 1972 Sixteen bills proposed in 12 states; two enacted. HWA adopted guidelines which prohibited smoking in conference rooms and auditoriums in its buildings and required no smoking sections in its cafeterias.
- 1973 Thirty-six bills proposed in 18 states; five enacted. Many municipalities enacted restrictive ordinances. The Arizona restrictive law and its promoter, Mrs. Betty Carnes, received wide publicity. The CAB ordered commercial airliners to separate smokers and non-smokers.
- 1974 Sixty-two bills proposed in 29 states; five enacted. Several municipal ordinances restricting smoking also were enacted. The ICC restricted smokers to the rear 20 percent of seating space on interstate buses.
- 1975 One hundred sixty restrictive smoking bills introduced in 48 states; 17 enacted. The Minnesota Clean Indoor Air Act restricted smoking in a broad range of public and commercial areas. The New York Health Department prohibited smoking in public areas, including supermarkets.

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1976

One hundred sixty-one bills proposed in 39 states; eight enacted, including the Utah Clean Indoor Air Act, another broad no smoking bill. Lawsuits were filed against the Pontiac, Michigan, Stadium Authority and the New Orleans Superdome by anti-smokers seeking to prohibit smoking in the buildings. The court dismissed the Superdome action and the Michigan lawsuit was settled with an agreement that the stadium would request the public not to smoke except in concourses. The ICC prohibited smoking in railroad dining cars and required separate passenger cars for smokers and non-smokers. Donna Shimp sued her employer, New Jersey Bell Telephone Company, and obtained an injunction requiring the company to provide her with a smoke-free working environment. Ms. Shimp was an ex-smoker who claimed she had a rare eye condition which was aggravated by tobacco smoke.

10.

1977

One hundred thirty-six restrictive bills introduced in 44 states, 13 enacted. The General Services Administration (the caretaker for U. S. Government buildings), the State Department and the Department of Defense enacted restrictive smoking guidelines for buildings under their control. The FAA rejected a petition by a Nader group which requested a prohibition against smoking by pilots on the flight deck of airliners. The CAB voted to prohibit pipe and cigar smoking in interstate airlines and announced that it would consider a rule prohibiting cigarette smoking.

11.

1978

As of May 1, 97 restrictive bills were introduced in 25 states, and three were enacted. As a part of HEW's "War on Smoking" program, HEW promulgated new restrictive smoking rules for buildings under its control and announced its intention to urge businesses and state and local governments to adopt restrictive smoking rules. California GASP and Californians for Clean Indoor Air obtained sufficient signatures to place a broad anti-smoking initiative on the ballot for the California general election in November. Twenty-six restrictive measures were proposed in local governments and eight have been enacted. In April the New Jersey Public Health Council added a broad no smoking in public provision to the New Jersey Sanitary Code, which is enforceable as law, effective July 1, 1978. Implementation of the new Code provisions may be delayed at the request of the New Jersey legislature.

12.

Anti-smoking groups have continued to enjoy their greatest successes at the local government level. Most major cities now have restrictive smoking ordinances. There are

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more than 225 local governments with restrictive ordinances reported to the Tobacco Institute. The actual number is probably larger.

THE LAWS AND ENFORCEMENT

Thirty-two states and the District of Columbia have enacted legislation restricting smoking in at least one category of public places. Of those 32 states, the majority have enacted prohibitions or restrictions applicable to elevators, public transportation, theaters, museums, libraries, concert halls, health delivery facilities, health care facilities, government buildings and public meeting places. Six of the 32 states have prohibited smoking or require segregation of smokers in retail stores, food stores, and restaurants. Two states (Minnesota and Utah) extend their restrictions to privately owned places, including offices where more than one person works.

14.

The Minnesota Clean Indoor Air Act is one of the two broadest state restrictive laws in the United States and has become the model for anti-smoking legislation. The law prohibits smoking in public places except in designated smoking areas. The Act defines "public place" as:

15.

...any enclosed, indoor area used by the general public or serving as a place of work, including, but not limited to, restaurants, retail stores, offices and other commercial establishments, public conveyances, educational facilities, hospitals, nursing homes, auditoriums, arenas and meeting rooms, but excluding private, enclosed offices occupied exclusively by smokers even though such offices may be visited by nonsmokers.

Smoking areas may be designated by proprietors of public places, provided that:

16.

...where smoking areas are designated, existing physical barriers and ventilation systems shall be used to minimize the toxic affect of the smoke in adjacent nonsmoking areas.

Current trends in state laws and local ordinances actually enacted are the extension of smoking restrictions to cover government-owned buildings, grocery stores, supermarkets and health care and delivery facilities. The major trend in the bills introduced, reflecting the ambition of anti-smoking supporters, is the extension of restrictions into the workplace, including offices.

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Reported enforcement activities appear to be the result of either official priorities set by the local administration or, more frequently, random efforts by local GASP chapters to obtain enforcement of the laws.

18.

In Chicago, smoking on Transit Authority trains and buses is punishable by fines of \$50 to \$300. Offenders are tried in "Smokers' Court," where more than 800 people were convicted in 1975. People who could not post the \$25 bond had to spend the night in jail. Even those who could post bond often had to spend several hours in custody before cutting the red tape and winning release. Smokers have been taken bodily from trains because they protested their arrest. Ninety percent of the arrests have involved minority and low income groups.

19.

However, in most cities which have enforced public smoking laws, actions have resulted from private complaints and citizens' arrests made by private individuals, usually members of GASP. Most reports of enforcement from citizens' arrests come from California cities. The laws of most states do not authorize a citizen's arrest for violation of no smoking laws, but in California smokers can be arrested by fellow citizens.

20.

Yet the primary impact of smoking restriction laws may be the creation of a no-smoking norm in public places. The Commissioner of Dade County, Florida, admitted that that county's anti-smoking ordinance was virtually unenforceable but added:

21.

But it's being morally enforced; it's the people, the people in the elevators, the clerks in the stores and the nonsmokers in the check-out lines, who by their remarks to offenders are enforcing the law. It's being enforced by people who want to obey the law and I'd say it was 85% to 90% effective.

The impact of no-smoking laws on the cigarette market has not been accurately measured. However, to gauge the impact it is helpful to remember that the average smoker in the United States consumes 1.5 packs per day. If it is assumed that smoking prohibitions in public places caused the average smoker to consume one less cigarette per day, total consumption in the U.S. would be reduced by 1/30th.

22.

THE MEDICAL FACTS

In 1971, Jesse L. Steinfeld, M.D., who served as U.S. Surgeon General from 1968 to 1973, said:

23.

Evidence is accumulating that the nonsmoker may have untoward effects from the pollution his smoking neighbor forces upon him.... It is high time to ban smoking from all confined public places such as restaurants, theaters, airplanes, trains, and buses....

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There was no evidence in the speech, and there had been no evidence in previous Public Health Service (PHS) reports to Congress on smoking and health signed by the Surgeon General (commonly called the Surgeon General's Report). In fact, a previously published PHS booklet entitled "Smoking, Health, and You" stated that the smoke from other people's cigarettes "may make your eyes tear or may make you cough, but it cannot harm you...."

24.

The next report to Congress on smoking and health, the 1972 edition, for the first time cited reports indicating that ambient tobacco smoke could be harmful to nonsmokers. The evidence was not convincing and strong contrary evidence was omitted.

25.

Anti-smoking groups have repeated Dr. Steinfeld's claims in forums throughout the United States and have expanded them to include assertions about a variety of potential injuries to nonsmokers from exposure to ambient tobacco smoke.

26.

The anti-smokers' claims that nonsmokers can be injured by ambient tobacco smoke are not supported by scientific evidence. It is instructive to examine a few of these claims in the light of scientific and medical knowledge.

27.

Toxic substances: Anti-smokers often present a list of so-called "toxic" substances in tobacco smoke as proof that ambient tobacco smoke can be harmful to the nonsmoker.

28.

For example, cigarette smoke contains hydrogen cyanide. Anti-smokers may also say that ambient tobacco smoke includes "side stream" smoke (the smoke which goes directly into the air from the burning end of the cigarette) which has higher concentrations of some substances than the smoke inhaled by the smoker.

29.

These charges ignore the fact that first, the concentrations of these substances in ambient tobacco smoke are minute and, second, these substances are readily diffused in the air.

30.

Allergy: Anti-smokers often complain that many nonsmokers are allergic to tobacco smoke. ASH, for example, asserted in a recent submission to the Civil Aeronautics Board that as many as 30 to 34 million Americans "have a particular sensitivity to tobacco smoke."

31.

There is genuine question whether tobacco smoke has been shown to be or contain an allergen. Dr. Domingo Aviado, Professor of Pharmacology at the University of Pennsylvania Medical School and an internationally recognized expert, made the following statements:

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...should a true tobacco smoke allergy be shown to exist, which has not been done, it would be quite rare. Estimates that large numbers of persons are allergic to tobacco smoke are unsupported by scientific data.

The method of determining whether an allergy exists has not been settled although many allergists make use of a skin test using tobacco leaf extract. Such skin testing is not at all comparable to exposure to tobacco smoke.

There is a major scientific difference between an allergy and an annoyance or an irritation. Individuals may be irritated or annoyed by a wide variety of airborne substances but not necessarily allergic to them.

What about ~~asthma~~? There is no objective scientific evidence to support the claim that ambient cigarette smoke adversely affects the lung function of asthmatics. In a 1977 study by Pinn, Shephard and Silverman, asthmatics were exposed to cigarette smoke in a small test chamber. The researchers were unable to find any significant changes in their lung functions.

Carbon Monoxide: Another claim is that the carbon monoxide in tobacco smoke is poisonous, severely affects a person's "test performance" and can cause cardiovascular and respiratory diseases.

* ~~Numerous~~ studies have shown that carbon monoxide concentrations in enclosed areas resulting from cigarette smoking are very low and do not present an inhalation hazard to the nonsmoker. ~~These studies include~~ actual carbon monoxide measurements and studies of the physical reactions of non-smokers (e.g., Harke 1972).

Auto exhaust and industrial fumes are, by far, the major sources of carbon monoxide in the daily environment.

To support the claim that smoking can produce higher carbon monoxide concentrations, anti-smokers have cited a study involving smoking in an automobile. However, the volume of the car involved was only 73.8 cubic feet, which is equivalent to a cube with sides of 4.2 feet each, and all windows and vents were closed.

In 1977, the FAA considered a petition by anti-smoking groups requesting a rule prohibiting tobacco smoking on the flight deck. The contention was that exposure to relatively low levels of carbon monoxide causes substantial impairments to vital brain and nervous system functions. The FAA carefully considered several studies and ruled that the petition did not disclose adequate reasons to justify the rule it requested.

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Produced by R.J.R.T.C

It is interesting to note a few carbon monoxide equivalents. One automobile driven 12 1/2 miles emits more carbon monoxide than a 1.4-pack-per-day smoker contributes to the atmosphere in an entire year. A Washington, D.C., Council of Governments study found that cars and trucks account for 92 percent of the carbon monoxide released into that region's air. The FAA measurements of carbon monoxide emissions from one Boeing 707 in its 33 minute landing-takeoff cycle is 202 pounds, the same amount as emitted from smoking 1.3 million cigarettes.

Nicotine: In 1975, two Harvard investigators, Hinds and First, measured the concentrations of nicotine in public places in Boston, such as restaurants and cocktail lounges. They demonstrated that in "public places nonsmokers could potentially consume 1/1,000 to 1/100 of one filter cigarette per hour, a level of exposure that has had no known serious association with disease."

In other words, for a nonsmoker to inhale the equivalent of one filter cigarette from ambient tobacco smoke he would have to spend from 100 to 1,000 continuous hours in a smoke-filled bar.

Nonsmokers With Compromised Health: Anti-smokers often argue that exposure to tobacco smoke causes stress to persons with severely compromised cardiovascular systems.

Because a delicate condition is presumed, it is impossible to establish a "no effect" level of carbon monoxide exposure for these persons, and there is some evidence that they may be adversely affected to some degree by any exposure sufficient to raise the carbon monoxide blood level.

This situation is indeed unfortunate. However, reference to this category of people as a reason for prohibiting smoking in public places ignores the fact that they may be subjected to discomfort and stress in the course of their normal daily encounters with carbon monoxide from automobile exhaust fumes and other air pollution. It has been stated that the only adequate protection for these persons would be to maintain them in an "oxygen-enriched" environment.

THE NON-PROBLEM

A study of cigarette smoking in aircraft conducted jointly by HEW, the FAA and the Department of Transportation concluded that the inhalation of ambient tobacco smoke aboard commercial aircraft "does not represent a significant health hazard to nonsmoking passengers." The result of the study was first announced in 1970, prior to the time of Surgeon General Steinfeld's statement that evidence showed ambient tobacco smoke could be harmful to nonsmokers.

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The ICC held extensive hearings in 1970 on smoking in buses. Although the ICC decided to segregate smokers on the basis of annoyance it found that the asserted deleterious effects of second-hand smoke upon the health of motor bus passengers had not been adequately demonstrated.

47.

Dr. Edwin R. Fisher, Professor of Pathology at the University of Pittsburgh and Director of Laboratories at the Shadyside Hospital in Pittsburgh, said in October, 1977 that a careful review of research literature failed to support the conclusion that ambient tobacco smoke represented a health hazard to nonsmokers. Dr. Fisher said:

48.

The few studies that might appear to be contrary to this conclusion can, in my view, be rather readily dismissed for reasons of improper experimental design and lack of practical significance. For example, some studies use unrealistic quantities of smoke or fail to consider other sources of the agents being studied.

Even several eminent researchers and government officials who are well known for their opposition to tobacco use agree that public smoking is not harmful. Dr. Gio Gori of the National Cancer Institute said, "If we want to remain with facts and not with fiction, there is little danger of disease to people that stay in a room where people smoke."

49.

Dr. Reginald Stallones, an advisor to the Surgeon General's Advisory Committee on Smoking and Health, recently said, "In very direct terms there is no medical proof that non-smokers exposed to cigarette smoke in ordinary relation with smokers suffer any damage."

50.

Dr. E. Cuyler Hammond, vice president, Epidemiology and Statistical Research, of the American Cancer Society and author of famous studies linking smoking and lung cancer, was reported to have made statements to the International Conference on Public Education About Cancer in 1974 as follows:

51.

Dr. Hammond stated that there was "no shred of evidence that a non-smoker can get cancer from 'second hand' smoke and there is a lot of evidence that he cannot...." He added that to suggest passive smoking (inhalation of smoke by non-smokers) could cause cancer is dishonest, and that he would be prepared to testify as such in court.

It is apparent that anti-smokers' claims that nonsmokers are subject to injury by ambient tobacco smoke are not supported by scientific evidence.

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CHECKLIST OF ARGUMENTS

The following suggestions are intended to be guides for writing or speaking in response to anti-smoking arguments on public smoking actions. It is important to remember that health or scientific arguments can be ineffective in communicating with the general public. On the other hand, most people can clearly identify with arguments based on freedom of choice, and many people feel strongly that the "hand of government" should not interfere with their private lives.

53.

Restricting smoking in business establishments should be up to the proprietor.

54.

Every restaurant, hotel, and other public establishment is presently free to establish no smoking areas if this is the desire of patrons. It should be the proprietor's choice based on customer demand and "the marketplace."

The fact is that a majority of public establishments do not have no smoking sections. A survey by the National Restaurant Association confirmed that few members of the public actually desire separate sections for smokers and nonsmokers.

"The public smoking issue" can be resolved on the basis of common courtesy.

55.

Most smokers will show respect for the wishes of those around them.

Public smoking laws present grave enforcement problems.

56.

During the prohibition era this country learned of the great difficulty government has in enforcing matters of social morality and conduct. Unless the police go on rounds to arrest an individual as soon as the person lights up in a no smoking area, it will be practically impossible to enforce public smoking laws effectively.

To the extent that shop owners and other proprietors are expected to be enforcers of these laws, they will be subject to difficult dilemmas. If a smoker lights up in a no smoking section, can the owner of a restaurant ask the person to extinguish the cigarette without risking the loss of patronage?

In light of serious U.S. crime problems, it is foolish to take police away from critical duties to determine whether a cigarette has been lighted in a no smoking zone. Yet if such laws are not

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vigorously enforced, their flagrant violation can breed further disrespect for the law.

How can anyone justify the cost of enforcing public smoking laws?

57.

Taxpayers are usually not aware of the high cost of restrictive ordinances. For example, it was reported that a San Diego public smoking ordinance cost taxpayers \$20,000 merely to get the law on the books in January, 1975. Complaints to the Police Department there cost over \$70 each for the officer's time, processing, paper work and court action.

Public smoking laws will place a substantial burden on individual proprietors and on the economy.

58.

This is particularly true when public smoking laws require the erection of physical barricades, improvements of the air circulation system, and other capital expenditures. The costs of compliance with such laws can be substantial. In addition, many establishments may be so small that they cannot effectively segregate smokers and nonsmokers.

A restaurant's economic success depends on maximum peak-hour traffic. Restricting the use of a small area at that time can cause losses. Customers also can become irritated. For example, a smoker arriving to find a line waiting for the smoking section, when the no smoking section is empty, may be understandably angry. Whenever a patron is turned away, the proprietor risks losing that customer's business forever.

Efforts to attract conventions would be dampened by the risk that conventioners could be fined or jailed for lighting up in the wrong location.

Should an individual's smoking in public be criminally restricted by government actions?

59.

Is jail really the appropriate place for an individual whose "crime" is lighting a cigarette?

How far will government go to restrict our private lives?

60.

There are obviously many public annoyances to everyone in their daily lives. The "bad" or conflicting behavior and manners of other people in public places can cause substantial

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irritation. The noise and fumes of heavy traffic, the dissatisfaction toward public services like sanitation and law enforcement, the irritation from dirty streets, barking dogs, noisy neighbors or even the weather can certainly be more severe than the diffused smell of tobacco smoke in a ventilated public place.

Should laws also be passed to ensure good manners and behavior, and, if so, by whose standards? Any effort to extend government regulation into these areas would result in a massive interference with an individual's personal life and freedoms.

The public smoking issue may be best summarized by an editorial appearing in the Boulder Camera, (Boulder, Colorado, January 22, 1975):

It's one thing to legislate conduct for the protection of society--to restrict behavior that endangers the life, health or safety of others. It is quite another to legislate against conduct that merely annoys. Hardly anybody can avoid annoying somebody else occasionally. When government gets one foot into the realm of behavior modification, the blue-law thicket looms ahead.

Smokers' wishes should be respected, too.

61.

The question of segregating smokers is really a matter of balancing the convenience and preference of smokers and nonsmokers. Although nonsmokers certainly have interests that must be considered, smokers also should be accommodated. The best and most effective method of balancing those desires and interests is through common courtesy on both sides, without the imposition of rigid and unworkable government requirements.

This nation does itself no service when unnecessary social conflict arises from the advocacy of misstated and erroneous health concerns.

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QUESTIONS & ANSWERS

Individuals associated with the tobacco industry often are confronted by thought-provoking questions regarding smoking and health, public smoking and other issues which make up the controversy surrounding the industry. In the past, employees have not been adequately equipped to deal with these questions. Brown & Williamson prepared this handbook in an effort to inform employees with a depth of knowledge surrounding the issues.

The following section includes a series of questions and answers covering a variety of issues. These questions have been accumulated from media interviews and discussions with a variety of groups by Brown & Williamson and industry spokespersons. The following questions and answers are not intended to make "spokespersons" out of Brown & Williamson employees, but they are intended to better inform our managers.

Q: Does smoking cause lung cancer, emphysema, cardiovascular disease and bronchitis?

A: No one knows. Scientific research has not established that smoking causes illness. We all know some scientists have said smoking causes illness, but many respected scientists believe cause has not been shown. More research is needed.

Q: How can you deny the overwhelming statistical evidence that smoking causes disease?

A: The case against smoking is based almost entirely on inferences from statistics. But most scientists will agree that statistical associations cannot establish cause and effect. Statistical associations are only clues which show the need for clinical and laboratory experiments. There are other flaws in the statistical arguments, such as the reliability of the data. By the way, there is a statistical association between lung cancer and the use of electric razors. We need more biological research.

Q: When you look at lungs taken from smokers and nonsmokers, it's obvious that smoking has damaged the lungs of the smoker, as compared to the lungs of the nonsmoker. This proves that smokers are damaging their lungs.

A: Perhaps you've seen the rather grisly exhibit set up by the American Cancer Society which contains two specimens of lung tissue, one which is smooth with a light cream color and the other which has warts and is coal black. One lung is said to be from a smoker and the other from a nonsmoker. You can guess which is which. The exhibit is deceptive because it represents that the differences in the tissues are typical results of smoking. This is not true. A former president of the College of American

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Pathologists testified before a Congressional Committee that: "I have examined thousands of lungs both grossly and microscopically. I cannot tell you from examining a lung whether or not its former host had smoked....I state flatly and unequivocally and emphatically that cigarette smoking will not turn the lung black."

Q: Do you deny that smoking is hazardous to your health?

6.

A: No one knows. Many respected scientists believe that a causal relationship between cigarette smoking and illness has not been proven.

Q: Do you claim that the benefits of smoking outweigh the risks?

7.

A: Whether or not to smoke is a choice to be made by informed adults based on individual assessments. Obviously many people derive some value from smoking because it has been a popular custom for hundreds of years. Columbus found the American Indians smoking, and sales of tobacco leaf supported the Jamestown Colony.

Q: How can you smoke when you know you are causing health problems to nonsmokers in the same room?

8.

A: Smoke in the ambient air is not harmful to the health of the nonsmoker. Even medical experts who have been associated with the charge that smoking causes lung cancer in the smoker have said that smoke in the ambient air has no influence on the health of the nonsmoker.

Q: Why are manufacturers producing more low "tar" and nicotine cigarettes and advertising those brands heavily if there is no health risk involved in smoking high "tar" and nicotine cigarettes?

9.

A: Cigarette manufacturers are producing low "tar" and nicotine cigarettes in response to consumer demands for those products. Their perception of the growth of the low "tar" segment is correct. Sales of cigarettes with less than 15 milligrams "tar" content increased by more than 50 percent in 1976 and comprised roughly 25 percent of the total cigarette market in 1977. Only a few years ago low "tar" and nicotine cigarettes were an insignificant part of the market. This very rapid shift shows the cigarette manufacturers' eagerness to respond to customers' changing preferences. The advertising emphasis simply reflects the shift in consumer demand. No cigarette manufacturer has said there is no health risk involved in smoking high "tar" and nicotine brands. As with the question of smoking and disease in general, no one knows.

Q: How much money does the tobacco industry spend each year in advertising to attract new smokers?

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A: None. Cigarette advertising is brand advertising. Its purpose is competition against other brands for consumers, not to attract new smokers.

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- Q: Nine out of ten smokers say they want to quit. Shouldn't the government help them by sponsoring quit-smoking programs? 11.
- A: Each adult individual must make up his own mind whether to smoke. The tobacco industry is not interested in preventing anyone from giving up cigarettes. Many private stop-smoking programs are available at little cost, and literature which describes ways to stop smoking is available from several sources. Many people have stopped without a formal program. It is not necessary to spend taxpayers' money.
- Q: Doesn't the cigarette industry feel some responsibility for the \$8 billion cost to the United States for health care and \$18 billion cost to the United States in loss of production time caused by cigarettes sold? 12.
- A: The charge is based on the assumption that smoking causes illness, but causation has not been established by scientific research. There are other difficulties with the figures. For example, the figures assume the need for health services included would disappear if no one smoked cigarettes. With our aging population, this is unlikely.
- Q: Doesn't the nonsmoking majority in this country have the right to vote that cigarettes should not be smoked in public places? 13.
- A: No! Such a law would be completely unjustified as a function of government in our society. Tolerance is the cornerstone of this country's democracy. There is no health danger to nonsmokers -- the problem is annoyance. This is a social matter which must be left to people to resolve in social situations through mutual courtesy. Laws dictating personal social conduct, arrests, fines, and forced segregation are inappropriate means of dealing with a social situation. If there are going to be laws prohibiting smoking in public places, there should certainly be laws prohibiting strong perfume, body odor, and untrained pets.
- Q: What would you tell your child if he asked you whether he should smoke cigarettes? 14.
- A: I would tell him to wait until he was an adult and then make up his own mind. Whether to smoke is a choice for the individual and a choice that should be made only by informed adults.
- Q: How do you account for the fact that so many government and scientific societies have passed resolutions asserting that smoking causes lung cancer and other human diseases? 15.

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A: The fact that government bodies and scientific societies have passed such resolutions indicates that the continuing controversy over smoking and health is political, not scientific. Scientific issues in the medical field are settled by definitive biological experimentation, not by the passage of a resolution. There have been no experiments proving that cigarette smoking causes illness, and that is why activists in government agencies and scientific organizations have resorted to resolutions to establish their personal opinions.

Q: Don't all of the medical experts in the United States agree that smoking causes lung cancer?

16.

A: As a matter of fact, many scientists in the United States hold the view that smoking has not been scientifically established as a cause of lung cancer. They note that no one knows the cause or causes of lung cancer. Nor does anyone know the mechanism or mechanisms whereby this disease develops.

Q: Won't you concede that smoking is a prime suspect as a cause of lung cancer?

17.

A: Scientists generally agree that lung cancer is a multifactorial disease, i.e., it has been statistically associated with many factors. These include occupation, geographical location, sex, urbanization and several others as well as smoking. But factor does not mean cause. Whether any of these suspects plays a role in the causation of this disease is as yet unknown.

Q: Aren't there cancer-causing agents in tobacco smoke? Don't they explain the association between smoking and lung cancer?

18.

A: For more than 20 years now, cancer researchers have been trying to identify components in tobacco smoke that are harmful to human health. To date, however, they have not identified any ingredient or group of ingredients, as found in tobacco smoke, that are disease-producing in humans.

Q: Doesn't tobacco "tar" produce cancer in animals?

19.

A: Contrary to popular belief, human smokers are not exposed to tobacco smoke condensate — commonly referred to as "tar." Tobacco "tar" is a laboratory product that is produced by passing tobacco smoke through a cold trap at an extremely low temperature — a temperature that human smokers simply do not experience. Hence, the relevance of animal experiments with tobacco "tar" is dubious. And it should be remembered that, despite great efforts by many scientists, human-type lung cancers have not been produced in laboratory animals as a result of exposure to tobacco smoke.

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Q: Hasn't lung cancer in women begun to increase as they have begun to smoke more?

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A: There has long been a wide gap between the incidence of lung cancer in males and females and this gap has not been satisfactorily explained in terms of smoking. As to the recent reports of increased cancer in women, some scientists believe that this disease has been increasing in women for many years, which is not consistent with a smoking-causation hypothesis. There are other considerations. For example, the lung cancer increase reported in women is usually of a different type from those reported as predominant in men and, in fact, is a type not generally considered associated with smoking.

Q: Isn't nicotine known to cause disease in humans?

21.

A: In 1964, after reviewing the then existing literature, the Advisory Committee to the U.S. Surgeon General concluded that the small amount of nicotine absorbed by tobacco use "probably does not represent an important health hazard" to humans. Since 1964 there has been no scientific evidence which would warrant a change in this conclusion.

Q: What about heart disease? Isn't it pretty well established that smoking causes this disease?

22.

A: Heart disease is a multifactorial disease, i.e., one which has been statistically associated with many factors. So far, more than 20 factors have been identified. Factor does not mean cause. No one knows whether any of the observed factors plays a role in the causation of the disease. Recent studies of identical twins suggest that a person's genetic background may be the most important factor. Other studies indicate that a person's personality type is the prime factor.

Q: What about people who are allergic to tobacco smoke? How can they protect themselves from smoke in the atmosphere?

23.

A: Although many people talk about tobacco allergy, it has never been established that tobacco smoke allergy exists. Scientists simply do not know whether or not tobacco smoke -- as opposed to tobacco leaf -- contains allergenic components.

Q: Aren't cigarettes addictive?

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A: It is difficult to discuss addiction today because people apply the term to many different circumstances. Some people say they are addicted to chocolate; others say their children are addicted to TV. The 1964 Surgeon General's report concluded that cigarettes

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should be classified as habitative, like coffee, and not addictive, like morphine. Many people have given up smoking. Why do some people continue to smoke who say they want to quit? Why do people continue to overeat when they say they are too fat?

Q: Isn't modern cigarette advertising an improper business practice because it has a heavy impact on children and leads them to smoke?

25.

A: Cigarette advertising is intended for adults only. For example, cigarette advertisements show no models who are under 25 years of age, no entertainment celebrities and no athletes. Cigarette advertising can establish brand loyalty -- and that is its purpose -- but it does not attract new smokers. No studies have shown that cigarette advertising causes children to smoke. Dr. Ernest L. Wynder, president of The American Health Foundation, said he did not believe cigarette advertising had much influence on smoking.

Q: What questions were left unanswered by the 1964 Surgeon General's report?

26.

A: Many questions were left unresolved. Why, for example, do nonsmokers fall victim to heart disease, lung cancer and other diseases frequently associated with smokers? If, as some anti-smoking groups claim, cigarette smoking is the major cause of lung cancer, why is it that the vast majority of the "heavy" smokers never develop the disease? Why hasn't independent scientific research been able to identify any one or combination of the thousands of components as found in cigarette smoke as the cause of any particular disease? Why in more than forty years of research hasn't anyone been able to reproduce the type of lung cancer associated with smoking--through tobacco smoke inhalation--in laboratory animals?

Q: Will the anti-smoking movement succeed?

27.

A: The anti-smoking movement is actually proposing prohibition. According to Dr. Peter Bourne, Special Assistant to the President for Health Issues, such proposals are not realistic. In remarks to the Ad Hoc Committee on Tobacco and Smoking Research of the American Cancer Society on November 10, 1977, Dr. Bourne said, "Because of the political, social and economic ramifications, it is unrealistic for us to suggest a tobacco prohibition as a feasible short-term goal, and that campaign would bring into question our own credibility. It is there that we are on our weakest ground. While prohibiting use of cigarettes in public places would please nonsmokers, it would not necessarily reduce overall cigarette consumption or reduce the health consequences. We have done little research on the hazards, if any, of other people's cigarettes."

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- Q: What is the tobacco industry doing to help resolve the smoking and health controversy?
- A: In the last 24 years the tobacco industry has provided more than \$70 million for independent research regarding questions related to smoking and health. In many of these years this commitment has exceeded that of any government department, and has been substantially more than the research expenditure reported by all the voluntary health associations, who spend a major portion of their donated funds for administration and for public relations campaigns. The tobacco industry is committed to advancing scientific inquiry in this area.
- Q: Do the tobacco companies control the research they sponsor?
- A: Absolutely not! The commitment of the tobacco manufacturers to resolve the smoking and health controversy has never been fully appreciated. Grants are made with no strings attached except a pledge to apply the money to legitimate scientific research. Each researcher is free to publish his study results, whatever they may be.
- Q: Does it bother your conscience to sell cigarettes?
- A: Absolutely not! The tobacco industry is a \$15 billion industry affecting 17 million people. As far as the health question is concerned, no valid research has ever established that cigarette smoking causes illness. Nevertheless, every pack of cigarettes carries a warning label as required by law. A person would have to be a "cave dweller" not to be aware of the warning. We live and work in a country which supports the free enterprise system. It gives its citizens the freedom of choice. We should continue to enjoy that freedom both in our business and in our personal lives.

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THE OPEN QUESTION

For many years, certain individuals and organizations have claimed that smoking causes a large number of diseases. Such claims are largely based on studies which have reported statistical associations between smoking and various diseases.

However, such associations alone can never establish cause-and-effect relationships. The most that such data can do is to indicate areas for further scientific research. Unfortunately, scientific data that contradict the popularly-held belief that smoking causes disease are generally ignored or severely criticized without adequate justification.

It has become easier to indict smoking as the sole source of our medical problems than to confront the data which show an existing scientific controversy and the need for further well-defined objective research to establish the facts. The following discussion will highlight some of the topics mentioned above.

SMOKING AND LUNG CANCER

The evidence cited to implicate cigarette smoking as a cause of lung cancer has been provided primarily by statistical studies, such as the Hammond and Horn survey of white American men in nine states. However, such studies have been seriously questioned. For example, in 1958, Dr. Joseph Berkson of Mayo Clinic observed that "Cancer is a biologic, not a statistical, problem." More recently, a British physician noted that "the cause of cancer of the lung is not known. We have only statistical inferences and forecasts.... Until it is discovered no one who values scientific evidence should assume that cigarettes cause cancer of the lung."

In 1977, a South African physician who reviewed some of the original statistical studies which are used to support the claim of a causal relationship discovered errors in the analyses of the data. As a result of these discoveries and other observations, he concluded that "The smoking hypothesis has received emphasis which it really does not deserve." He added that "This hypothesis has to be abandoned."

One of the most pertinent facts to be kept in mind when claims about smoking and lung cancer are considered is that some reported statistical data are not consistent with the causal hypothesis. For example, researchers have reported large variations in lung cancer mortality rates in a number of countries which cannot be explained by differences in

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tobacco consumption. Austria, Belgium and Finland report higher lung cancer rates, but considerably lower per capita tobacco consumption than the United States, Canada and Australia.

Lung cancer mortality rates may not be reliable because they are based on the often inaccurate information regarding cause of death as shown on death certificates. This conclusion is supported by the finding of researchers who compared clinicians' diagnoses of lung cancer with autopsy results and found serious discrepancies. Such errors may have resulted in part from the clinicians' difficulties in determining whether a cancer originated in the lung or had spread to the lung from another site.

The reported increase in lung cancer, said to be of "epidemic" proportions, may be greatly overestimated. Experts have suggested that the reported increase may be an artifact created largely by improved diagnostic techniques. The recent intense interest in lung cancer may also have resulted in an over-diagnosis of the disease.

Experiments in which laboratory animals are forced to inhale tobacco smoke have failed to prove the hypothesis that smoking causes lung cancer. Not only has the relevance of such experiments been questioned, these techniques have failed to produce in animals any lung tumors which are of the type associated with human smoking.

Much of the interest in the causation theory was generated by skin-painting experiments in which tumors were produced by painting "tar" (a laboratory product obtained by passing tobacco smoke through a cold trap at extremely low temperatures) on the shaved backs of animals. However, these experiments are inappropriate for comparison to the inhalation process of humans, for several reasons. The skin of an animal is not at all similar to human lung tissue. Furthermore, the application of a substance to the skin is quite different from inhalation. Finally, there is no "tar" as such in tobacco smoke, and even if there were, the quantities used in such experiments are unrealistic.

In an effort to determine why some people develop lung cancer while others do not, a number of scientists are studying the "constitutional hypothesis." This hypothesis states that some people who have a hereditary predisposition for lung cancer also have a hereditary tendency towards smoking. It is supported by research which shows that smokers differ from non-smokers in many physiological and psychological characteristics.

Occupational and environmental factors, such as air pollution, have also been found to be associated with lung cancer. Concern has been expressed that the concerted effort

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to prove that smoking is the primary cause of this disease may be diverting attention from such factors.

Any serious discussion of the claims linking smoking and lung cancer must include consideration of the following two facts:

1. Lung cancer was an established disease long before cigarette usage became popular.
2. Most smokers do not develop lung cancer, while many non-smokers do.

SMOKING AND CORONARY HEART DISEASE (CHD)

In efforts to determine the cause of coronary heart disease, researchers have examined a variety of behavioral, physiological and environmental factors which have been associated with an increased risk of this disease. Cigarette smoking is considered by some to be one of these so-called "risk factors."

For example, the 1976 Public Health Service Report on The Health Consequences of Smoking describes smoking as "one of the major independent CHD risk factors." However, available data do not provide consistent support for the identification of smoking as a risk factor. For example, an international study by Keys found "little or no" relationship between cigarette smoking and coronary heart disease in Finland, the Netherlands, Yugoslavia, Italy, Greece and Japan. Furthermore, several studies cited to support the role of smoking in the development of coronary heart disease contain data inconsistent with this claim. In one such study, coronary heart disease mortality rates actually were lower in ex-smokers than in nonsmokers.

Researchers also have studied a number of other factors which appear to be associated with an increased prevalence of this disease. For example, some scientists have observed specific behavior patterns that appear to be associated with an increased prevalence of CHD. This coronary-prone behavior pattern, called Type A, is characterized by such traits as aggressiveness, ambitiousness, time consciousness, and a chronic sense of urgency. Other scientists have concluded that there is a strong genetic component in the development of CHD. Studies of twins and familial coronary heart disease patterns have provided support for this theory.

The stresses normally encountered in daily life also have been positively associated with coronary heart disease. Researchers have found that severe financial problems, occupational tensions, and life-style changes have produced physiological alterations which may lead to coronary lesions. One

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investigator, who studied the mortality statistics of 100,000 physicians who reportedly had quit smoking, commented:

It is evident that there has been no increase in the average age of death among physicians during the past 16 years. . . . While it is possible that the full results of this abstinence (not smoking) have not yet been seen, the resolution of underlying stress rather than smoking per se may be the crucial factor. . . . These findings are consistent with the apparent predisposition of doctors to coronary heart disease, a vulnerability which can be attributed to the stresses in their way of life.

Therefore, the indictment of cigarette smoking as a major risk factor in coronary heart disease mortality is contradictory to each scientific fact.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Claims have been made that cigarette smoking causes COPD, a term which refers primarily to chronic bronchitis and pulmonary emphysema. Such a claim was made in the most recent report on smoking by the Royal College of Physicians of London called "Smoking or Health."

However, these claims are contradicted by statements of scientists and governmental officials who note that the cause or causes of these chronic lung diseases are still unknown. For example, a special report supplied by the Department of Health, Education and Welfare for use during consideration of its 1979 budget request indicates that "the exact cause of emphysema is not known"

Such statements are supported by an examination of cigarette consumption patterns which exhibit no consistent relationship with COPD incidence rates and mortality trends. This is illustrated by the fact that individuals who have never smoked develop COPD but many smokers do not. Moreover, large international variations in COPD mortality rates cannot be explained by levels of tobacco use.

Certain animal inhalation studies have been cited as proof that smoking causes COPD. However, serious questions have been raised about the adequacy of the experimental techniques employed and the relevance of the results to man. For example, ~~anatomical~~ structural differences identified in the respiratory systems of mammals may complicate the extrapolation of animal test results to the human situation.

Some researchers who have examined the reported increase of COPD in cigarette smokers speculate that it may be

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the result of basic psychological and/or physiological differences between smokers and nonsmokers. For example, even when smoking habits are similar, blacks seem to have a lower incidence of chronic bronchitis and emphysema than whites.

Occupational exposures may also play an important role in the development of COPD. A scientist familiar with occupational exposures recently wrote that the available evidence does not support claims that smoking is the major hazard to workers' lungs; he concluded, "... it's their jobs which seem to cause their illness."

In recent years, ambient air pollution has received increasing attention as a major cause of COPD. Lave and Seskin have concluded that "mortality from bronchitis would be reduced by about 50% if air pollution were lowered to levels currently prevailing in urban areas with relatively clean air." They continue:

The studies document a strong relationship between all respiratory disease and air pollution. It seems likely that 25% of all morbidity and mortality due to respiratory disease could be saved by a 50% abatement in air pollution levels.

Therefore, claims that smoking causes COPD must be seriously considered in light of this evidence.

SMOKING AND PREGNANCY

Claims have been made that smoking during pregnancy causes adverse effects, in particular that smokers are more likely to have low-birth-weight (LBW) infants. Some claims have even been made that smoking increases the risk of congenital malformation and perinatal mortality. However, these claims are based on statistical data which are at best equivocal and, furthermore, cannot prove causal relationships. Moreover, there are data which are inconsistent with certain of these claims.

Low-Birth-Weight Infants. A biostatistician who examined and was unable to accept the causal hypothesis contended that the data he studied may suggest the existence of some other common factor which causes women both to smoke and to have a higher proportion of LBW infants. Yerushalmy advanced this theory in a 1972 report describing data which, he later said, "almost clinch the argument against causation:"

This conclusion follows from the finding that women who eventually became smokers produced a large proportion of low birth weight infants even before they started to smoke. . . .

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To explain these findings, Yerushalmy speculated that the higher incidence of LBW infants among smoking women may be due to the smoker, rather than the smoking.

Yerushalmy's finding are supported by the results of other research projects, including two studies in which the researchers concluded that smoking apparently does not cause LBW but may serve as "an indicator" or "an index" of some other factor or factors that may be involved.

The need for further research on the relationship between maternal smoking and LBW was recognized by Silverman in a report on her study which had been designed to determine whether smoking causes LBW, or whether smokers are "a self-selected group that differs from nonsmokers in ways unrelated to smoking. . . ." Although she wrote that her findings were not conclusive, she observed that "The direction of the observed differences in mean birth weights is more consistent with the self-selection hypothesis."

Although these studies have failed to disprove either the causal or self-selection hypotheses, several have shown that smokers' LBW infants appear to be healthier than non-smokers'. Yerushalmy, for example, noted that LBW infants of smokers "are much healthier" than those of the nonsmokers and that the "healthiest" low-weight babies were born to couples in which the wife smoked and the husband did not.

Increased Perinatal Mortality. Scientific evidence does not support the claim that maternal smoking during pregnancy is causally associated with increased perinatal mortality. Several large studies, including those by Yerushalmy, Underwood, The Ontario Perinatal Mortality Study Committee, Rantakallio, and Targett have found no increase in the perinatal mortality rate of infants of smoking mothers. As the National Academy of Sciences Committee on Maternal Nutrition concluded in 1970, ". . . smoking is not significantly associated with excess fetal or neonatal mortality. . . ."

Congenital Malformation. Several large-scale population studies also have failed to establish a relationship between smoking and congenital malformation.

In a study of 51,490 pregnancies, for example, the Ontario Perinatal Mortality Study Commission found "no evidence that smoking was associated with a higher incidence of congenital malformations." Yerushalmy and Hollingsworth both reported that their studies showed that the risk of congenital malformation in LBW infants was lower for smoking than for nonsmoking mothers.

The available scientific evidence does not warrant the conclusion that a causal relationship between smoking, LBW, increased perinatal mortality and congenital malformation has been proven.

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CIGARETTE SMOKE COMPONENTS

Despite much repetition of the claim that certain substances in tobacco smoke are harmful to the smoker, it has not been scientifically proven that any component or combination of components as found in tobacco smoke causes disease.

These claims, which focus primarily on "tar," nicotine and carbon monoxide (CO), have led to proposals for establishing maximum levels of such substances in tobacco smoke. Such a recommendation currently is being considered by the Department of Health, Education and Welfare as part of a major anti-smoking initiative launched by Secretary Joseph Califano.

The following discussion describes some of the inadequacies of the scientific evidence for the claimed health effects of these three substances.

"Tar." There is no "tar" as such in cigarette smoke. The substance called "tar" is actually a laboratory product obtained by collecting the particulate matter in tobacco smoke. This hardly simulates what humans are exposed to in the smoking process. That is why quotation marks are often used around the word "tar" when referring to tobacco smoke.

"Tar" is not smoke. There is no good reason to assume that any biological activity of whole smoke can be accurately determined by studying "tar." The chemical and physical changes necessarily brought about in condensing the smoke and applying the substance to animals may well produce biological results completely different from any that may occur during smoke inhalation.

Nicotine. Nicotine has historically received as much experimental attention as "tar." However, nicotine, in the amounts found in tobacco smoke, has not been scientifically established as hazardous to smokers. Even the 1964 Report to the Surgeon General on Smoking and Health concluded that nicotine as found in tobacco smoke "probably does not represent a significant health problem." After thirteen years of intensive research, no data have been developed which would warrant a change in that conclusion.

Nicotine has no known chronic or cumulative effects. It is rapidly absorbed and metabolized by the human body into other simpler substances which exhibit no established harmful pharmacological activity. According to the 1964 Report to the Surgeon General, "Nicotine is rapidly changed in the body to relatively inactive substances with low toxicity."

Despite these statements, some smoking opponents have claimed that nicotine causes cardiovascular disease. However,

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this claim was clearly contradicted in testimony by a government witness at the 1976 hearings on cigarette smoking and disease. Dr. Theodore Cooper, then Assistant Secretary for Health, Department of Health, Education and Welfare, indicated that he considered smoking a risk factor for cardiovascular disease, but not a cause:

Senator Hart: ...I would merely ask if cigarette smoking causes heart disease?

Dr. Cooper: No.

Senator Hart: It does not?

Dr. Cooper: No.

Carbon Monoxide. This tasteless, odorless gas is present in tobacco smoke, but it is also present in the air we breathe. The predominant man-made sources include the exhaust fumes of automobiles and emissions from industrial processes. Furthermore, carbon monoxide is a natural body constituent created by normal metabolism.

As with "tar" and nicotine, the experimental evidence regarding ~~several~~ health effects of CO, as found in cigarette smoke, is at best inconsistent. Studies of humans who are consistently exposed to low doses of CO have reported no increase in the incidence of heart attack or circulatory abnormalities.

Possibly because experiments with humans have failed to prove their claims, anti-smoking advocates have emphasized the results of animal experiments by certain researchers. Yet when animal experimentation is examined as a whole, it also fails to provide consistent results on the effects of CO exposure. Moreover, the recent research findings of one of the scientists frequently cited as having demonstrated a link between carbon monoxide and heart disease did not confirm the conclusions about the effects of carbon monoxide drawn in his earlier studies.

Such evidence indicates that the claims made about the health effects of certain constituents of tobacco smoke on the smoker are just that--claims which are not established by scientific proof.

RESEARCH

The ~~scientific~~ commitment of the tobacco industry is clear. For nearly 25 years the cigarette manufacturers have been supporting totally independent research with completely non-restrictive funding. The results--whatever they are--may be published wherever the researcher chooses.

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Hundreds of researchers in medical schools, hospitals and other scientific institutions in this country and abroad have received more than \$70 million from the tobacco industry to support their investigations.

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The findings of scientific studies funded in whole or part by the cigarette companies comprise more than 2,000 papers published in the world's professional literature.

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The Council for Tobacco Research - U.S.A., Inc., an industry-sponsored agency, has the major responsibility for the evaluation and funding of research proposals. Research support has been implemented mainly through a program of grants-in-aid, supplemented by contracts for research with institutions and laboratories. The Council does not operate a research facility.

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The position of the tobacco industry is that the questions raised by the smoking and health controversy can be resolved only by sound scientific research.

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